Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 8 2009 Year **Physician** 11:15 AM Titial Virginia Mayhew /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany 100 Kolberg Hill Westernport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCt. 1 5. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Days West Virginia 1 M 2 F 1934 233-84-1742 74 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Allegany Westernport 1X Yes 2 □ No MD. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 Kolberg Hill United States 21562 by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 25No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 🎎 No Specify: Specify. 3√Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene, Important: If item 27 is marked other than "in any injury or other traumatic event, the Madione. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Elliott Riley Mary Irene Daughtery ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 32, Westernport, Maryland George E Mayhew / son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Westernport Maryland Philos Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee - Warre 111 Church St, Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** reams disease or condition resulting in death) /Medical Due to (or as a conse un nce of): Examiner in Won any Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 ☐ Unknown icate has been sig , page 2 should b 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2▼No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: The certificate 1 ☐Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 27. Manner of Dath 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Addical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Dong H. Lee

State Registrar 912

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registrar's Signature

Seton

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uiw	_		State Registrar 1. Decedent's Name (First, Middle, La	and)		Certifica	ite of D	eatn	2. Date of De	Reg. Ná U	0)	3. Time of Death
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<u> </u>	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	n yrs. last bir		er 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir			place (State or Foreign
, ``	Director		293-01-8128	1 K M 2□F	91	Yrs.			DECEMBER	pate of Birth Month, Day, Year) EMBER 17, 1917 9. Birthplace (State or Fore Country) OHIO		
and	W	-	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Tow	n or Location				10d. Inside City Limits		
Maryl	f sho	ţō	MARYLAND HOWA	ARD			COLUN	ВIA				1 ☐ Yes 2X No
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r dea	er mi	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. Was Dec	edent of Hisp pecify Cuban,	anic Origin? (Sp Mexican, Puert	pecify Yes or No o Rican, etc.))- 14. R B	ace - Ameri lack, White,	
36 s afte	or li	by Fi	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates:	1943- 1945	1 ☐ Yes	2 X No	Specify:		Spec	oify: WI	HITE
-00 Phour	al Ey		15. Decedent's E	ducation		Decedent's Us	sual Occupati	on	16b. Kind of Business			ndustry
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e, l	if of Health and Mental Hygiene. If Item 27 is marked other than "natural" or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		VIVIAN M. McNEELE 20a. Method of Disposition			f Disposition (N		COURT,	Date	A, MAK) 20c. Location		
Francis McNeeley Baltimore, Maryland 21215-0036	ent of t: If It y or o		1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			WRIDGE	MEMORI	AL FEBR		TT WAT	NOTE N	(ADVI AND
Car Iltin	Department of Important: If any injury or once.	ŀ	21. Signature of Funeral Service Lice		PARK	22. Name	and Address	of Facility FEI	LOWS, H	ELFENBI	IGE, M	ARYLAND D NEWNAM
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Ph	nysician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the yone cause on each line.	e death. Do	not enter the m	ode of dying,		or respiratory a			Approximate Interval Between Onset and Death YS
	Medical xaminer	_	resulting in death) Sequentially list conditions,	b. Due to (or as a co	ylin	of): Dysp	hagia					days year:
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Division or Vital Records, P.O. Box 687 or Attending Physician: The law requires that the death certificate	as been signed by the attending physi 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23d. Date of companies 2									very Day Year
rds, P.	n signed by	۾	Part II. Other significant conditions	contributing to death but n	not resulting i	n the underlying	g cause given	in Part I.		tobacco use co Yes 2□ No		the cause of death?
Division or Vital Records, P.O.	certificate has beerector, page 2 sho	Completed							24a. Was auto perf 1□ Yes	an 24 ppsy ormed? 2 2 No	death?	topsy findings available ompletion of cause of
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Or \	this c	2	1 ☐ Yes 2 No	·		utpatient 3□		4 Nursing F	lome 5 ☐ Res	•		eify)
on C	After this funeral di	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 280.	Time of Injury M	28c. Injury a Work?	at es 2⊡No	280. Describe	how injury occ	urrea	
isic	death.	icat	2 Accident investigation 3 Suicide 6 Could not be		- At home, fa			2 2 110	28f. Location	Street and Nu	mber or Ru	ral Route Number,
Div	after Direction by	Certification:	4 Homicide determined	28e. Place of injury building, etc. ((Specify)	,,	,		City or To	wn, State)		
E Hospital	4 hou Fune tely fil	Medical C	29a. Certifier (Check only one) 29a. Certifier (Check only one) Check only one)									
To the	To the	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D								n, Day, Year)		
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	0,00	M	30. Name and address of person who	OWLLY &	ns	(Type, Print))UTCH	man's	LANG	EAST	W M	10 21601
*	Sta Registr		31. Date filed (Month, Day, Year) FEB 13 20	32. Redistrar's	s Signature	back	/					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06503 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Ronald A. Miller, Sr. 11, 2009 February 5:40P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bradford Oaks Nursing Home Clinton Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F Months Days Hours Min Director 577-64-1393 6/1/1946 Usual Residence of Decedent to or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Temple Hills the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? death with ral", or Items 23a 6015 Hope Drive 20748 USA Funeral permit. Peges 1 and 2 should be filed within 72 hours after deat Depertment of Health and Mental Hygiene. Important: If fem 27 is merked other the any Injury or other trainments. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married þ 1 ☐ Yes 2 🔀 No Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Educator Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rose I. Miller Unknown ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6015 Hope Dr., Temple Hills, MD 20748 Velmar G. Miller/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake 2/17/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Lot Puneral Service Loren 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARUMMA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to mini surface cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy detached for Month Day Year 5 ☐ Other (specify) 2 □ No 1 □ Yes P.0. 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Tursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation after death.

Director: Af in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours

State Registrar

Medical

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29b. Signature and title of certific

29a. Certifier

(Check only one)

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day VERDELLE MANN 3:03 P /Medical FEBRUARY 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BOWIE HEALTH CARE BOWIE PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, APRIL 3 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months Days Hours Min. 1930 GEORGIA 78 176-28-2781 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show rotified 1 Yes 2 No Director MD PRINCE GEORGE'S BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, I're Medical Examinations to be i 16205 AUDUBON LANE 20716 USA death ! Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Yes 2 No filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 **BLACK** 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Completed by Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE if Health and Mental Hyg Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be NELSON C. JACKSON ELIZABETH -DAYဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AUDUBON LANE BOWIE, MARYLAND 20716 CHARLES MANN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State to ! ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. RIVERDALE CREMATORY 2/18/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine The law requires that the death certificate be executed PROSTHETIC AORTIC VALVE attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🔀 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2√ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed? Yes 2 \(\Delta\) No certificate 1 ☐ Yes 2 🖾 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) CLINIC 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending

P.O. Box 68760, of Vital Records, Hospital or Attending Physician: Division death. 24 hours after deatl Funeral Director: in by the completely filled

investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Medical To the within 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) D28195

FEBRUARY

17, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID A, GOORAY M.D. 1450 MERCANTILE LANE SUITE 217 LARGO, MARYLAND 20774

State Registrar

P.O. Box 68760. Division of Vital Records, e Hospital or Attending Pl 124 hours after death. e Funeral Director: After ti To the within 2

Baltimore, Maryland 21215-0036

Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier fonetion, mo V21936 February 23, 2009 30. Name and address of person who completed cause of death (item 23a) (Type, Print) FREDERICK MD THOMAS VOHNSON DR 21702 DONELSON AD ANDREN 65C 31. Date filed (Month, Day, Year) 32. Registrar's Si State DHMH 17 Rev 1/2001 **ORIGINAL**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decement's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician MILE +41NCy 1201 ٥c /Medical 0 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Davs Hours 492-44-9835 65 Director MARCH 17, 1943 MISSOURI Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evantical must be motified at t0a State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1MYes 2□No Directo ANNAPOLIS MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 CEDAR LANE 21403 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Gives 1962–1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ENGINEER DEFENSE CONTRACTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBERT LAWSON MILES MARY FLORENCE JENNINGS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TERRY MILES/WIFE 319 CEDAR LANE, ANNAPOLIS, MARYLAND 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. MARYLAND TVETERANS () 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CEMETERY - HURLOCK HURLOCK, MARYLAND 2009 21. Signal Funeral Service License FELLOWS Add HELFENBEIN & NEWNAM FUNERAL HOME, 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician disease or condition 5mm /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending I for use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not 23e. Did tobacco use contribute to the cause of death? esulting in the underlying cause given in Part I þ icate has been si, , page 2 should b 3 Probably 4 Unknown 1 Tes 2 🔯 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 25 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1∐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 | Pending nours after death.

neral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number

19 42

State Registrar 30. Name and address of person

31. Date filed (Month

e of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** February 6, 2009 Mitlehner Dorothy 3:12 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Homewood at Crumland Farms Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 1 1 F 69 Oct 20, 1939 123-30-2649 New York Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 27 No Frederick Frederick Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 7400 Willow Road 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Home Call Business Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Schmitt Margaret Reddock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elise Weston-Dawes daughter 8413 Buckhannon Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2-11-2009 Stauffer Crematory FRederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Tolune 1621 Opossumtown Pike, Frederick, Maryland Camelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstructive Relming Disine Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CANL Jnn Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ CAn Up Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has pade certificate Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🚾 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ÷ P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 ⊟ Natural 2 ∐ Accident Division 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Martha Jane Pierce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

300 @. 9th Street, Frederick, Maryland

Darke

746248

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/200

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended#31perFCHD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Gladys Ε. Nicholson 2009 4:30 February 11 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mt. 1132 Village Gate Drive Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □ M 2 🖾 F Months Days 20, 214-32-8284 90 1918 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Frederick Mt. Airv 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21771 United States permit. Pages 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene Important: If item 27 is marked other than 'natural', or items 23s any highry or other traumatic event, the Modical Examinations once. 1132 Village Gate Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White λq 1 Tyes 2 No Specify 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager 6 Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Della E. Nicholson ပ John W. Nichols 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dennis Nicholson / Son 1132 Village Gate Drive Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 14, 2009 Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ridgeville Blvd. Mt. Airy, Maryland 21771 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** P /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖾 No 2 X No 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed /Month

29b. Signature and title of

30. Name and address of person who conducted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

FEB 17 2009

29d. Date signed (Month, Day, Year)

Beneva B. parks

363 2-14-09 Rd. westminster md-21157

			For State	State	of Maryland		artment of I		d Mental Hy	/giene	2009	06510
			Registrar 1. Decedent's Name (First, Middle	(act)		Cei	lilicate of	Dealli	2. Date of De		2007	3. Time of Death
	Physicia	an	Kathleen Col		hes Olse	n			Month Feorus	Day	4, 2009	3:00 P M
1	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of De			County of Death	0.00
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 H Hours Mi		rth av. Yearl	9. Birthp	lace (State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mary -f sho	ţ	MD Freder	ick	Roset	mont						1 □Yes 2 No
	r 28a	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cour	itry?
	h wit	alD	3618 Petersvill	e Road			21758			USA		
	ems	ne	11. Marital Status		cedent Ever in U.S		Was Decedent of I	Hispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Americ Black, White, e	
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Mar	a s a s		19a. Informant's Name/Relations Lawrence D. Ols		nd				Rural Route Numb		or Town, State, Zip) 21758	Code)
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ē	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from			matory or other pla . Cremato		/18/09	Ode	enton, MD	
	permit. Pages Department of Important: If its any Injury or o	l (i	21. Signature of Funeral Service		11			-			P.O. Box	
n	B 3 2 6 3	0	Devely 7	Holi	tts MO1	251 B€	verly L.	Heckro	tte. P.A.	Cla	rksville	MD 21029
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death each line.	. Do not ent	er the mode of dy	ng, such as card	liac or respiratory	arrest,		Approximate Interval Between
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1	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	ience of):	- 1	- 1				
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8760	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dical		d								
ý : X	ding pare as	/Me	IF FEMALE:	220 Haves o	uteeme of progne	nov						
Rox	eath certific attending p for use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna e birth 2□ Fetal gnant at time of d	death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date of delive Month	ery Day Year
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Vital	lysician: The lis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ot	her:	Death (Check only			
ō	ding Phys h. After this funeral dir	<u>ان</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1L	Inpatient 2 e of Injury	28b. Time o	IL 3 LI DOA	4 LI Nursing	g Home 5 Res 28d. Describe		6 ☐ Other (Specif	(y)
5	nding tth. : Afte e fune	tion	1 Natural 5 Pendin 2 Accident investi	g (Mo	onth, Day, Year)	Injury	Wo	rk?]Yes 2 ☐ No	250. 200020	· · · · · · · · · · · · · · · · · · ·	, y coodinod	
Division of	or Attending Physician: ifter death. Director: After this certific in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be ined 28e. Plac	ا ce of Injury - At ho ding, etc. <i>(Specif</i>)	ome, farm, str	eet, factory, office		28f. Location	(Street an	nd Number or Rura	al Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Sertifyir (Check only 2 Medical one)	ig Physician: To the Examiner: On the and ma								
	To th within To thi compl	Me	(Check only only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signer 29								ate signed (Month,	Day, Year)
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(1	(1)		30. Name and address of person Kanan H. H	who completed ca	use of death (Item	23a) (Type,	Print)	usm Di	rive Fre	deri	ch, M	21702
Ĭ	Sta Registr		31. Date filed (Month, Day, Year)	3 2009 32.	Pegistrar's Signat	ture,	backer		- /			

	State of Maryland / Department of 1-For State Certificate of	Dooth	eg. No. 2009 0651
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Shanik Plater	2. Date of Deat Month February	
	4a. Facility Name (if not institution, give street and number) University Hospital	Bb. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $218-19-9188 \qquad \text{1 M 2X F} \qquad 20 \qquad \text{Yrs}$	Months Days Hours Min.	th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
nd how any see.	Usual Residence of Decedent 10a. State	on Frederick	10d. Inside City Limits 1 Yes 2 X No
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5-0036 led within 72 hours aft tygiene other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedend during m	t's Usual Occupation (Give kind of work done ost of working life. DO NOT use retired)	Campus Security
21215-0036 uld be filed within 7 Mental Hygiene event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Milton Plater	18.Mother's Name (First, Middle, I Evelyn	Gross
MD 21 nd 2 should slith and Mc m 27 is ma aumatic en	Evelyn Plater 300 M	Address (Street and Number or Rural Route Nu	nber, City or Town, State, Zip Code) rederick, MD 20678 1 20c. Location - City or Town, State
Baltimore, MC permit Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traums	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		Prince Fred., MD
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	ne mode of dying, such as cardiac or respiratory arr	
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P.O. B es that the d igned by the be detached I by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	and onlying dated given in	obacco use contribute to the cause of death? s 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirer safter death an Director. After this certificate has been signed in by the funeral director, page 2 should be ertification: To Be Completed		24a. Was autop perfo 1 ✔ Yes	prior to completion of cause of death?
Vital Resystician: The his certificate director, pag	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: ✓ Inpatient 2 ER/Outpatient	26.Place of Death (Check only one) 3 DOA Other Nursing Home 5	Residence 6 Other:
ision of Attending Physic death by the funeral ication: Tication: Tication: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 X Accident Investigation 2 28a. Date of Injury (Month, Day, Year) 1 2/21/08 5:08 at	m 1 Yes 2X No driver collis	
Division o Blospital or Attending 4 hours after death Funeral Director: Aft filled in by the fune al Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) roadway 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	Mt. Zio	Street and Number or Rural Route Number, City State Southern MD Blvd. & n Marlboro Rd Lothian,
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investiga and manner stated. 29b. Signature and title of certifier	ition, in my opinion, death occurred at the time, date 29c. License number	and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
	30. Name and andress of person who completed cause of death (Item 23a)	O.C.M.E.	February 17, 2009
State	200 P *** 1 0	1 Penn Street, Baltimore, MD 21201	

			For State	State of Maryland				nd Mer			711119	06512
			1 - State Registrar AMEND#26pe 1. Decedent's Name (First, Middle, La	MD2/13/09,BMW, st)	MoCo.	imodic or i	Douin		Date of De			3. Time of Death
	Physici: /Medic		Lillian T. Pamp	illonia					Month Feb.	11, Day	2009 Year	9:00 A M
	Examin	er	4a. Facility Name (If not institution, given			4b. City, Town, or				4c.	County of Deat	th
-	Funeral		Brighton Garden 5. Social Security Number 6. S		st birthday)	Chevy C	If Under 24	Hrs. 8.	Date of Bir	th	ontgome 9. Birl	thplace (State or Foreign
	Director		578-22-4955	I□M 2ᡚF	Yrs.	Months Days	Hours I		(Month, Da			w York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation						10d. Inside City Limits
	Maryl Fsho	tor	MD Montgom	Ch a	Ch							1 □Yes 2¥ No
	th the	Director	MD Montgom 10e. Street and Number 5555 F	riendship Blvd	vy Ch: #310	10f. Zip Code	00015			10g. Citi	zen of What Co	L ountry?
	ath wil			1			20815			USA		
	2 should be filed within 72 hours after death with the Maryland nand Mental Hygjene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evertinet must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) No	. 13. \	Vas Decedent of H FYes, specify Cuba	lispanic Origin an, Mexican, P	n? (Specify Puerto Rica	Yes or No an, etc.))-	 Race - Ame Black, White 	
036	ral", or	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1	□Yes 2X No	Specify:				Specify: Whi	te
5-0	72 ho "natur dien	Completed	15. Decedent's E (Specify only highest gro		(Give	lent's Usual Occup	durina most of	f working			nd of Business/	
12	within lene. than	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	Jewe	00 NOT use retired	a)			Ra	tail	
<u>م</u>	other other	Be C	17. Father's Name (First, Middle, Last	1	OCWC	ICI	18. Mother's	Name (Fi	rst, Middle			
ylar	ould be Menta arked atic ev	TO E	Dominick J. Pamp	illonia			Lill	lian 1	Mistr	etta		
Mar	f2 sho hand 7 is m traum		19a. Informant's Name/Relationship (Dominik Pampill			g Address <i>(Street .</i> Savannah				-	r Town, State, 2 20817	Zip Code)
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition			sition (Name of patory or other place		Date	sua,		cation - City or	Town, State
Ē	Pages nent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	nemoval from State		cremator	i	h 13	0.9	F-11	e Chur	ah Wa
ä ≅	epartn porta ny Inju		21. Signature of Funeral Service Lice		22	. Name and Addres	ss of Facility	Josep	h Ga	wler	's Sons	ii, va.
<u> </u>	20 5 % 3		William R.	Breyer		5130 Wisc					shingto	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final						-			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseque		le so tic	1100	xr /	1/15	e cash	2	Years
	Examiner		Coguantially list one ditions	h ———								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	inne of):							
)	execut al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		■ d								
Ö	ertifica ing ph e as th	Med	IF FEMALE:									
O. Box	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of de	death 3 □	Ectopic pregnanc	у			2	23d. Date of del Month	ivery Day Year
o.	uires that the de signed by the d be detached f	ysic	1 □Yes 2-15 No 9 □ Unknown	9 Unknown	atn 5L	Other (specify)						,
შ.	ss that gned t		Part II. Other significant conditions	ontributing to death but not result	ting in the ur	derlying cause give	en in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?
ord	w require been si should b	ted	Hypertension						1 🗆 '	Yes 2	□No 3□Pr	obably 4 🔀 Unknown
Records,	e faw has b	Completed by	Anorexia						24a. Was autor	osy	prior to	topsy findings available completion of cause of
_	sician: The law certificate has b irector, page 2 s		25. Was case referred to medical						1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	2 □No
<u> </u>	yslcia is cert direct	To Be	examiner? 1 \(\text{Yes} 2 \) \(\text{Yes} No \)	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3 DOA Othe	_26. Place of er: 4 □ Nursii				Assist	ed Living
Division of	ng Ph fter th	L.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		28b. Time of Injury	28c. Injur					occurred	ony)
Sio	ttendi death. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not b	1		M 1 □	Yes 2 □ No					
<u>></u>	after death after death Director: d in by the I	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, iarm, stre	et, ractory, office			City or To			ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to	Medical C		nysician: To the best of my know niner: On the basis of examination and manner stated.								
		Me	29b. Signature and title of certifier	1		29c. License	e number			29d. Date	e signed (Monti	h, Day, Year)
	1310		1 far		170	D333	57			2-	-12-200	9
			30. Name and address of person who Lee Jonathan Mus			orint) Sin Ave.#	1045	Chevy	Char	se. N	1D 208	15
	Sta	e	31. Date filed (Month, Day, Year)					511C V y	Jilai	, c, r.		
	Registra	ar	FEB 13 200	32. Registrar's Signatur	gar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Chester Alfred Picard February 13, 2009 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11750 Asbury Circle, Apt. 100 Calvert Solomons If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) November 12, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Director 036-09-5888 88 Rhode Island Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Calvert Solomons 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or Items 23a or edical Examiner must be 20688 11750 Asbury Circle, Apt. 100 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∑Yes 2 ☐ 1942—1945 If Yes, Give 1942—1945 Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Communications Officer Department of State 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Joseph R. Picard Amelia Carignan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brion M. Picard / Son 25144 Peregrine Way, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: If any Injury o Fairfax Memorial Park 02/19/2009 Fairfax, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee P.O. Box 600, Lusby, MD 20636 23a. Part1. Entir the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Failure to thrive disease or condition resulting in death) /Medical Due to (or as a consequence of): Obstrictive Pulmonary Discorde Examiner Chronic Sequentially list conditions, if any, leading to maneriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISCUSC 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an autopsy performe 1∏ Yes 2 No Be 26. Place of Death (Check only one)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; after death.

I Director: Al

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

5 Residence 6 Other (Specify)

29c. License number D562123

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 02/13/2009.

Vear

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 24035 Three Notch Road, Hollywood, MD 20636 Shahid R. Siddiqui, 31. Date filed (Month, Day, Year) 32. Registras's Signature

LEW 10+1 Registrar

Certification: To

cal

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Golch

and manner stated.

		For State Registrar		Ce	ertificate of			Reg. No.2 0	09	06514	
Physici /Medi		Decedent's Name (First, Mide		ae Porter			2. Date of Dea Month February	Dav	Year 09	12:50 P M	
Examir		4a. Facility Name (If not institution South River Rehabi			4b. City, Town, o	or Location of Deat	th	4c. County			
Funeral Director		5. Social Security Number 252-24-6358		ge (In yrs. last birthday 89 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Count	ry)	
show show	or	Usual Residence of Decedent 10a. State 10b. Count MD Calver	-	10c. City, Town or L					10		
th the N or 28a-f	Direct	10e. Street and Number		Trantingtown	10f. Zip Code			10g. Citizen of W	/hat Count		
death w ems 23a r.must b	Funeral Director	140 Ponds Wood R	12. Was Decedent	Ever in U.S. 13.	. Was Decedent of I	20639 Hispanic Origin? (S	Specity Yes or No-	USA - 14. Race	3. Time of Death 2009 12:50 P Mounty of Death 2 Arundel 9. Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits 1		
ite, INIAL YIAITU ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 □ Ma 3 ℃ Widowed 4 □ Divorce	rried 1 ☐ Yes 2 🛣	No	1⊡Yes 2⊠No	Specify:	no mean, etc.)	Specify	Bla	ick	
ithin 72 h ne. Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education lest grade completed) College (1-4or	5+) (Giv.	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo ed)	orking	111	16b. Kind of Business/Industry		
lal ylallu Z IZ 2 should be filed with and Mental Hygiene. Is marked other thar aumatic event, the N	Be	8 17. Father's Name (<i>First, Middle</i>	ə, Last)	Dom	estic	18. Mother's Na	me (First, Middle,			lse's Home	
should I	은	2 Silas Jenkins Am 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Numb								Code)	
	,	Willanette Lohr - G	ingtown, MD	20639							
partitione, IVI permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	3 □Removal from State (Specify)		position (Name of ematory or other plant Mem. Garde	1	Date /2009	20c. Location - Dunkirk, N	•	wn, State	
permit. Depart Import any in		21. Signature of Funeral Service	e Licensee	2	22. Name and Address	ĺ	51 Dares Rea	och Rd Princ	e Frede	wick MD 20678	
Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	-a. A+h	d the death. Do not er ine. <u>exolcle</u> s a consequence of):	_	2				Approximate Interval Between Onset and Death	
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
The law requires that the death certifate has been signed by the attending age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	s decedent pregnant he past 12 months? Yes 2 No 23c. If yes, outcome pripregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							•	
quires that n signed build be det		Part II. Other significant condi		_		ven in Part I.					
The law requires tate has been signe	Completed by	Preu mo	D1'4					rmed? d	leath?		
VICAL Iclan: T certificat ector, pa	Be	25. Was case referred to medic examiner?					eath (Check only o	one)			
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Penc 2 Accident inves	28a. Date of Inj		of 28c. Inju			dence 6 Other		·)	
ol or Attentate after deat I Director	Certification:	3 Suicide 6 Coul	d not be 28e. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>			28f. Location (S City or Tox	Street and Number wn, State)	er or Rura	Route Number,	
ne Hospita n 24 hours ne Funera sietely fille	Medical C	29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic	ring Physician: To the best al Examiner: On the basis and manner s	of examination and/or i	ath occurred at the t investigation, in my	time, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	nner as st and due to	ated. the cause(s)	
To the within To the comp	Me	29b. Signature and title of certiful 29b. Signature and title of certiful 29b. Signature and address of person 30. Name and address of person 29b.	fier	hua	29c. Licen	se number 5065	3	29d. Date signed	Month, I	0 ay, Year)	
Jew 2		30. Name and address of person	on who completed cause of	death (Item 23a) (Type	0751	1- De	are cl	withh	in R	d.	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

B. Sparker

32. Registra 's Signature

FEB 17 2009 ▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:25 PM 2009 100 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 3 M 2 □ F 064-28-766 YORK Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 201 OREGON ROAD 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROFESSOR EDUCATION** 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARJORIE SWARTHOUT DAVID SAMUEL PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DOROTHY JANE PALMER/WIFE 201 OREGON ROAD, STEVENSVILLE, MARYLAND 21666 20c. Location - City or Town, State 20a. Method of Disposition FEBRUARY 18 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 CHESAPEAKE CREMATION STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Lie 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONOROL Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 K Yes 2 □ No 3 □ Probably 4 □ Unknown

Physician /Medical Examiner

attending physician and for use as the burial-tran-

signed by the a

this certificate has all director, page 2 s

funeral

After

ours after death. leral Director; Aff filled in by the fur

To the Hospital within 24 hours a To the Funeral I

Be

Certification: To

Medical

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records.

Department of Health at Important: If item 27 is any Injury or other trau

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

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th and Mental Hygtene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner mast be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

altimore, Maryland 21215-0036

resulting in death) Last Physician/Medical IF FEMALE: 23h. Was decedent pregnant 1 Yes 2 No 9 Unknown Completed by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 📉 No 1 ☐ Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 □ No 27. Manner of Death 1 Natural
2 Accident

Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

5 ☐ Pending investigation 6 □Could not be 3 ☐ Suicide determined 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore mo

and manner stated

State Registrar 31. Date filed (Month, Day, Year, 18 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 8 2009 **Physician** 5:15 P Marquerite Pence /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Westernport Moran Manor Nursing Home 8. Date of Birth (Month, Day, March 9 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days Hours ^{Year)} 1920 220-10-1612 1 ☐ M 2 🖫 F 88 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examinar must be nettined at WV. Mineral Keyser MXYes 2 ∐ No Director 0g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 500 Carskadon Lane, Apt. 311 26726 death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc filed within 72 hours after 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Orland L. Biggs Martha Mae Liller Pages 1 and 2 should ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Robert Pence / son 212 Marsh Ave, Westernport, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Maryland Rest Lawn Mem Garden 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Boal Funeral Home 7 Wype 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Ronain Physician Stort kung disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation → Natural 1 □Yes 2 □No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Tild Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State of Mar State of Mar Registrar	ryland / Depa <i>Cei</i>	artment of H rtificate of L			ene 1. No. 2009	06517
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	/Medic	al	William McKinley Parks		41. Cit. To	Landing of Dank	February	3 2009	1608 M
	Examin	er	4a. Facility Name (If not institution, give street and number) The Memorial Hospita	3	East	Location of Death	Y	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0 Birthy	place (State or Foreign
	Director		235-30-6252 1X M 2□F	84 Yrs.	Months Days	1 louis IVIII1.	06/24/19	24	WV
	land ow		Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town or Lo	cation			1	0d. Inside City Limits
	a-fsh	ctor	MD Caroline	Goldsbo	ro				1 ☐ Yes 2 🛣 No
	ith the	Director	10e. Street and Number		10f. Zip Code		10g	p. Citizen of What Cour	ntry?
	sath w	Funeral	15060 Drapers Mill Rd.	ror in II C 12 1	21636		poifu Vas ar Na	USA 14. Race - Americ	oan Indian
ယ	or item	F	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No) I	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, White,	etc.
003	ural', c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	,	1 □Yes 2Å No	Specify:		Specify: Whi	
-5	filed within 72 hours after death with the Maryland Hygene. Hygene. brief than "natural", or items 23a or 28a-f show ent, the Medical Event har cust be retified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of worki	ng 16	6b. Kind of Business/In	dustry
212	d withi giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)		ating Eng			Steel	
nd	oe file tal Hy d othe event,	Be (17. Father's Name (First, Middle, Last)	•		18. Mother's Name	(First, Middle, Ma	iden Surname)	
yla	nould by Men	ပ	Louis McKinley Parks				le Venabl		
<u>⊠</u>	id 2 sh Ith and 27 Is r traur		19a. Informant's Name/Relationship (Type. Print) Frances V. Parks/Spouse		og Address (Street a			City or Town, State, Zip	21636
Ē,	s 1 an of Hea Item 3		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or To	
<u>ii</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Greenmoun			/2009 Hi	llsboro, M	TD .
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygene. Important: If them 27 is marked other than "naturaly," or items 23a or 28a-f show any injury or other traumatic event, the Medical Erandor and Landon any injury or other traumatic event, the Medical Erandor and Landon any once.		21. Signature of Funeral Service Licensee		Name and Address				1639
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ent	06 W. Sur er the mode of dyin				Approximate Interval Between
4.	Physician			consequence of):	trueti	a Polo	neward	Diseasa	Onset and Death
-	/Medical Examiner		resulting in death) Due to (or as a	consequence of):			1		
		Jer	Sequentially list conditions, b. u. to (ur as "locause. Enter Underlying Cause. Disease or injury	consequence of):					
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8760,	ficate be executed physician and s the buriat-transit		resulting in death) Last Due to (or as a	consequence of):					
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Box	eath certific attending p for use as	M/w	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 1 □ Live birth 2		☐ Ectopic pregnancy	1		23d. Date of deliv	
о В	Attending Physiclan: The law requires that the death certificate be executed to refeath. ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)	<u>'</u>		Month	Day Year
σ.	res that the signed by be detac		Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
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eco	e law re has be	Completed					24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
<u>а</u> Н	hysiclan: The la						performe	ed? death? No 1 ☐ Yes	2 046
Zi Zi	siclan certif irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 1 Hospital: 1 Hospital:	□ ED/0	ot all DOA Othe	04.	(Check only one)	- 50	
o	g Phy er this eral d	\vdash	27. Manner of Death 28a. Date of Injury	t 2 ER/Outpatier	IL 3 LI DOM	4 LI Nursing no	me 5 Residene 28d. Describe how	ce 6 Other (Special injury occurred	(y)
sior	r Attending Phy er death. rector: After this i by the funeral d	atio	2 Accident investigation	Year) Injury		Yes 2 □No			
Division of Vital Records,	or Attencafter death Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dirucompletely filled in I		29a. Certifier Certifying Physician: To the best of						
	To the He within 24 To the Fu	fedical	(Check only one) 2 Medical Examiner: On the basis of and manner state						
	5 w it	Z	29b. Signature and title of certifier) -	29c. Licenso			d. Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type		53110		ebruany	14,2009
			Dennis DeShields 219 S. Wa	ashington	St., East	on, MD	21601		
	Sta		31. Date filed (Month, Day, Year) 32/Registrar	's Signature	ulal				
	Registr	ar	FEB 17 2009 Comma	- 1. 19					

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) **Physician** Flora Mary ROHRER /Medical 4a. Facility Name (If not institution, give street and number) Examiner Washington County Hospital 5. Social Security Number **Funeral** Director 218-30-9655

28a-f show other traumatic event, the Medical Examiner must be notified at ö or items 23a "natural", al Hygiene.

10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☑ No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11525 Greenberry Road 21740 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other than any injury or other traumatic event, Inc. 2008. 12 Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Angelo Robucci Mitrione 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14914 Buchanan Trail West, Mercersburg, Pa. 17236 ce of Disposition (Name of Date 20c. Location - City or Town, State Donald W. Rohrer Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2/20/09 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ģ 2000 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 □ yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 1540 1 Department 2 ER/Outpatient 3 DOA Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie son who completed cause of death (Item 23a) (Type, Print) 30. Name and addre 580 Northern Ave OSH-2 hmood Mo 79 hid 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Months

Age (In yrs. last birthday)

85

Yrs.

1 □ M 2 🗓 F

4b. City. Town, or Location of Death

Hagerstown If Under 1 Year | If Under 24 Hrs.

Hours

Days

2. Date of Death

8. Date of Birth (Month, Day, Year)

Jan.

5 1924

Day February 18 occ.

POOG 81

Washington
9. Birthplace (State or Foreign Country)

West Virginia

3. Time of Death

705 AM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Walter Richardson Garv 9, 3:05 a^M February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min. 01/12/1946 Director 63 215-46-3838 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Director Calvert St. Leonard 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1331 Balsam Street 20685 U.S.A. Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married 0 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: 2 Specify: White 3 ☐ Widowed 4 ₺ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Self employeed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robinson Richardson Marian Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an 1331 Balsam Street, St. Leonard, MD 20685 Kasey Richardson/Son other t Department of Heal Important; If item 2 any injury or other Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/13/2009 Port Republic, MD 4 Donatio 5 Other (Specify) Chesapeak Highland 22. Name and Address of Facility ee Funeral Home Calvert, P.A. uneral Service L Lisa M. 8125 Southern Md Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final H0515 **Physician** ear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Later Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No. 9 Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy The perform 1 □Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determa 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. N.MD.

TRW State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ANWAR MUNSHI.MD

Allender 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. 110

32. Registrars Signature

HOSPITAL RUSUITE 303 PRINCE FREDERICK

MARYLAND 20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1, per MD 8891 5/11709 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Rosales 2. Date of Death 3. Time of Death February 12, 2009 **Physician** Rosales a.k.a. Loida Abigail Barillas de 4:35 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery 8. Date of Birth (Month, Day, Ye Feb. 18, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1951 1 □ M 2 🕇 F Days Months Hours Min. El Salvador 216-61-4259 57 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show rust be notified at Director 1 ☐ Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20906 IISA 23a 12911 Estelle Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. other traumatic event, I'm Medical Examiner Black, White, etc. 1 Never Married 2X Married 6 Salvadoran White 1 Ves 2 □ No Specify: Completed by Specify: 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Event Planner Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Manuela Cabrera Alberto Barillas ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Luis A. Rosales/Husband 12911 Estelle Road, Silver Spring, MD 20906 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or o 12 Burial 2 Cremation 3 Removal from State Feb. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 16 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility rancis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Cholangiocarcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

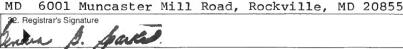
Funeral Director: After this certificate has been signed by the attending physician and eleiy filled in by the funeral director, page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospice Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the within 24 hours.
To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day, Year) FEB 13 2009

Jocelyne Kouatchou,

29b. Signature and title of certifier



and manner stated.

Diocellyne Kourtchou ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

of Vital Records,

Division

29c. License number

20063748

29d. Date signed (Month, Day, Year)

February 12, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Grace Louise Rawlings February 15 2009 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 145 Gertrude Dr Sunderland Calvert If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 1 1 2 7 1 9 2 2 5. Social Security Number 6 Sex 7 Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** Mary Land 1 □ M 2 🔀 F 86 215-26-3058 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □ Yes 2 □ No Director MD Calvert Sunderland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 145 Gertrude Dr Funeral 20689 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2 ▼ No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Private Home Care Giver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence Jones P Alverta Gross 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 270 Covent Ave New York, NY 10031 Martha Jones, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/21/2009 Sunderland, MD Hope Cemetery 21. Signature of Funeral Service Licensee W. Wesley Chavis III Funeral Service INC 10684 Southern MD BLVD Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic colon disease or condition resulting in death) months /Medical Due to (or as a consequence of): Examiner Physician/Medical þ Completed Be Medical Certification: To

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, has 9.2 s certificate ha within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ral", or Items 23a or 28a-f show Examiner must be notified at

an "natural", o Medical Exar

r than

7 Is marked other traumatic event, the

27

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
	pic pregnancy or (specify)	-	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? lo 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Other	ome 5 X Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how inj	
3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigand manner stated.	urred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
endeficet	DUD59061	Feb	may 17, 2009
30. Name and address of person who completed cause of death (Nam 23a) (Type, Print) Prati Pakel 110 HOSPI to Road, Six	lite 212 1	Prince Fr	edenck MD

dew State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #4aPer PHY &10e Per FH G891 5/05/09 Jh. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 06522 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frances Esther Ritter February 15, 2009 0850 /Medical 4a. Facility Name (If not institution, give street and number)

Asbury Circle

11450 Solomons Circle Uni 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Unit 221 Solomons Calvert Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year July 5, 19 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕏 F 76 215-44-4412 July Director 1932 Pennsylvania Usual Residence of Decedent 10a. State show 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dipertment of Health and Mental Hygiene.
Dipertment of Health and Mental Hygiene.
Dipertment of Health and Mental Hygiene.
The portant: I fine 23 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the "healtest Exminient nait to rottlifted at Director 1 ☐ Yes 2 ☑ No MD Calvert. Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Asbury Circle 11450 Unit 221 20688 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐ Yes 2 😿 No Specify: White 2 Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Condo Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H tem 27 is marked otk Be Richard Evans 2 Mary Phleegor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ritter (daughter) 821 Marie Lane Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 17 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2009 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee Gary J. Goff 8125 Southern Maryland Blvd. Owings. MD 20736 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute unknow /Medical Due to (or as a consequence of): Examiner unknown Sequentially list conditions, if any, leading to immediate cause. Enter the chips Cause (Disease or injury that initiated events resulting in death) Last ner Due to (as a consequence of): Examil burial-trar Due to (or as a consequence of): Box 68760. attending physician requires that the death certificate be Physician/Medical the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ξ 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2000 certificate 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 25 No Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending hours after death. Natural 5 Pending investigation within 24 hours after usa...

To the Funeral Director: After the Funeral Director of the funeral 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 Gwyneth A. Blattau, MD 110 Hospital Road Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4, Beverly Jean Rook February 2009 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 🗓 F 212-32-8105 Director May 15, 1934 Maryland Usual Residence of Decedent p-rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D-partment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Mental Indian Professional Office. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 □ No MD Garrett 0akland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 S. 3rd Street Completed by Funeral 21550 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ZA∐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 🎾 No 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cable Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James W. Flanigan ပ Mabel Shaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Rook, Daughter 561 S. 3rd Street, Oakland, MD21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Cumberland Crematory 2/9/2009 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, 21. Signature of Funeral Service Licensee 21 N. Second St., Oakland, MD Katherine Sweizer 23a. Part 1. Enter the disease, or complication. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed? 2 No 1 ☐ Yes 1 Tes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 1∐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 🗀 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D23979 February 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 311 N. 4th Street, Oakland, MD 21550 Goralski, MD Dr. Robert A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB - 9 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 2009 8:20P Francis Rickards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1022 St. Charles Drive Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 178-50-4121 50 Sept.13,1958 Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 No Maryland | Anne Arundel Directo Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and 1 21409 1022 St. Charles Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Non-Ferous Metal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis L. Rickards, Jr. Sabella 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Rickards/Wife 1022 St. Charles Drive Annapolis, MD, 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 2/13/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signat of Funeral Serval Ligensee alds 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 0 1 ☐Yes 2 XN 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) RD 300 150 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 11:50 PM RUSH MYRTLE IRENE FEBRUARY 10 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S BOWIE VILLA ROSA NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours Months 1 M 2 M AÚG. 1915 WASHINGTON, DC 12 229-07-2955 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified an once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 X Yes 2 No Directo PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 11401 KETTERING TERRACE 20774 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: AFRICAN AMERICAN Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TOUR GUIDE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be E. WILLIAMS **EMMA** JAMES CARTER ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11401 KETTERING TERRACE UPPER PETTROSS JR./SON MARLBORO, MD **GEORGE** 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/17/2009 RIVERDALE CREMATORY RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Sometire of Funer I Sa 22. Name and Address of Facility Licensee 60. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ADULT FAILURE TO THRIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Us to (or as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anter uns certificate has been signed funeral director, page 2 should be det <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 **™**No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 17, 2009 **FEBRUARY** D32261 completed cause of death (Item 23a) (Type, Print) 10 30. Name and address of person 9500 ANNAPOLIS ROAD SUITE A-4 LANHAM, MARYLAND 20706 FELDMAN M.D. RICHARD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FEB 1 R 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06526 State of Maryland / Department of Health and Mental Hygiene 19 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Reimers : 23 AM Elizabeth 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Daliss Hospice at Cake COMICO C 003/2/ If Under 1 Year If Under 24 Vrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) **Funeral** Months Jer sey 1 □ M 2 1 F New 129/52/7244 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If them 27 is amarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Event is at must be notified at any injury or other traumatic event, it a Medical Event is at must be notified at 1 ☐ Yes 2 ☐ No Berlin Worcester Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US A whaler 21811 14 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Keimers Cliused Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: white <u>م</u> 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Honemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Murphy Crain Elizabeth James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Berlin + MD 21811 tat Haglick Whaler Lane 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a, Method of Disposition Dover, Delaware 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 2/14/01 Capital Cr e matory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 61 SI Bradford St. > Stiller Owelderber TORBERT FUNCRAL CHAPEL 19904 DOJE! DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CINDUI TONGUIZ **Physician** MRTASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 menths? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 0 HO 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy perform After this certificate 1 ☐ Yes 24 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient HOSP143 Medical Certification: To 28b. Time of Injury funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation filled in by the 24 hours after death e Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar HOSPICA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COAS

32. Registrar's Signature

WANG

FEB 2 3 2009

-64

31. Date filed (Month, Day, Year)

0058410

P. Box 1733 Duy Bry mo 21802

DHMH 17 Rev 1/2001

State Registrar

12+195

KORAH

Rhades,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2

			For State Registrar	iale of Marylar		rtificate of		, 0	eg. No.2 () () 9	06528	
I	Physici	an	Decedent's Name (First, Middle, Last) CARLYNE	RUTH RASE	BERRY			2. Date of Deat Month Februar	Day Voor	3. Time of Death 4:55 A M	
	/Medio		4a. Facility Name (If not institution, give stree			4b. City, Town, o	r Location of Death	rebi dai	4c. County of Deat		
			Frederick Memorial	Hospital		Frede			Frederi	ck	
	Funeral Director		5. Social Security Number 218-54-7721 6. Sex	7. Age (In yrs. 59	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 18	Year) 9. Birt Co , 1949 Vi	hplace (State or Foreign untry) rginia	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation	<u>.</u>			10d. Inside City Limits	
	a-f sh	ctor	Maryland Frederick	Wa	alkersv	ville				1 ☐ Yes 2 ☐ No	
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number LOl Phoenix Court			10f. Zip Code 21793		1	0g. Citizen of What Co USA	untry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirer must be notified at once.	δ	1 □ Never Married 2 Married	Vas Decedent Ever in U Armed Forces? I ∐Yes 2 ☒ No fYes, Give ∕ear or Dates:		Was Decedent of HIf Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:		
Baltimore, Maryland 21215-0036	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12)	nn mpleted) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of work d)	ing	16b. Kind of Business/	Industry	
р Б	filed w Hygie ther t	ပ္ပ	12 17. Father's Name (First, Middle, Last)		Kesei	valions	18. Mother's Name	I			
an	ld be i lental ked o ic eve	To Be	Walter Robinett				Dorothy	,	nargon ourname)		
ary	s mar	۲	19a. Informant's Name/Relationship (Type. F	rint)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number	; City or Town, State, 2	Zip Code)	
Σ,	and 2 ealth n 27 i		Michael Rasberry - h						e, Marylan		
imore	Pages 1 ment of H lant: If ite		20a. Method of Disposition 11 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		lade Ce	osition (Name of matory or other place emetery	2-11	-2009 W		e, Maryland	
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee Maron (anull		uneral Hom derick, Ma						
	Control of the provided as the burial-transit as the burial-transi	cal Examiner	shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the contribution of that initiated events resulting in death) Last	Due to (or as a consecuence to (or a) (or	quence of):	cinoma				Interval Between Onset and Death	
.O. Box 68	the death certificat by the attending phy ached for use as th	Physician/Medical	in the past 12 months?	f yes, outcome of pregn □ Live birth 2 □ Feta □ Pregnant at time of □ Unknown	al death 3	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year	
rds, P.	quires that the de in signed by the ald be detached t	ρ	Part II. Other significant conditions contribu	ting to death but not res	sulting in the u	inderlying cause giv	ren in Part I.		pacco use contribute to	the cause of death?	
Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Be Completed	25. Was case referred to medical				26. Place of Deat	24a. Was an autops perform	y prior to death? 1 ☐ Yes	topsy findings available completion of cause of	
<u> </u>	hysici his cer I direc		examiner? 1 ☐ Yes 2 ☐ No Hospi	tal: 1 Inpatient 2] ER/Outpatie	nt 3 DOA Oth			ence 6 ☐ Other (Spe	cify)	
o u	ing P	.:uo	27. Manner of Death 2 1 ☑ Natural 5 ☐ Pending	8a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 28c. Inju	ry at k?	28d. Describe ho	w injury occurred		
Division of	al or Attend s after death il Director: ed in by the f	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	Be, Place of Injury - At h building, etc. <i>(Speci</i>	ome, farm, str fy)		Yes 2□No	28f. Location (St City or Town	reet and Number or Ru , State)	ıral Route Number,	
	ne Hospit n 24 houn se Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner:	n: To the best of my kno On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)	
	To th To th comp	M	29b. Signature and title of certifier	MD					9d. Date signed (Monti		
6	20		30. Name and address of person who comple Sandeep Sharma				et. Frede	rick. Ma	ryland 21	701	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa		barker					

		For State	State of Maryland				d Mental H	ygiene	Э	
		Registrar 1. Decedent's Name (First, Middle, L		Cer	tificate of	Death	0 D-4/5	Reg. No	2009	-06529
Physic /Med		BRENDA	HOLLENBAUGH		RA	KES	2. Date of D Month	Da		3. Time of Death 2 3+ PM
Exam		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of D			. County of Death	1
		THE DHNS HOKING 5. Social Security Number 6.		44:41 4 8	BALT7M	ORE C	174			
Funera Directo		215-56-1446	Sex 7. Age (In yrs. las	Yrs.	Months Days			Day, Year)	Cou	place (State or Foreign intry)
pu »		Usual Residence of Decedent		Taum and a	1		June	.0,19	JU Hal	
faryla shov ed at	ō	Maryland Cecil		Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2▼ No
r 28a-	Director	10e. Street and Number	1111	COII	10f. Zip Code			10g. Cit	izen of What Cou	
th with		69 Vista Drive			21921			Un	ited Sta	ites
yiand 21213-UU36 build be filled within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show attic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☆ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cub ☐ Yes 21 No	lispanic Origin' an, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Ameri Black, White Specify:	
215-0036 thin 72 hours af te. an "natural", or	Completed	15. Decedent's I (Specify only highest g	Education		ent's Usual Occup		working	16b. K	ind of Business/Ir	ndustry
d Z1Z15- filed within 72 Hygiene. wher than "na" ent, the Medic	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	O NOT use retired	d)	WOIKING			
filed v Hygie		12 17. Father's Name (<i>First, Middle, Las</i>	st)	_Bool	keeper	18. Mother's	Name (First, Middi		ucation_	
Maryland d 2 should be file th and Mental Hy 77 is marked oth traumatic event	To Be	Francis B. Gato	hell				Byrd	,	,	
E Sugar	-	19a. Informant's Name/Relationship					r Rural Route Num			ip Code)
C = C4 -	Ш	James W. Rakes /			ista Dri	ve, E1	kton, Mar	-		
altimore, rmit. Pages 1 ar partment of Her portant: If item y injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont	□Removal from State	netery, cren h Eas	natory or other place t Method	ict	oruary		ocation - City or T	•
Baltimo permit. Page Department of important: If any Injury or once.		21. Signature of Funeral Service Lice	<i>y</i> "	Cemet	ery	:18	, 2009 Crouch Fu	Nor	th East, 1 Home	Maryland
n ages		1 / llott		12	7 South	Main St	treet, No	rth		ry1and21901
		23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused the death. y one cause on each line.	Do not ente	er the mode of dyir	ng, such as car	diac or respiratory	arrest,	,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY		0515					4 MONTHS
Examiner			Due to (or as a consequer	,	LEVE	EMIA				2 YEARS
P ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen		-					707(103)
xecute and II-trans	Examine	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of):						
barbu, ficate be executed physician and s the burial-transit	dical E		√ d	,.						
rtificat ng phy	Ψ	IF FEMALE:								
O. BOX 68/6U, he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	rery Day Year		
w requires that the dibeen signed by the should be detached		Part II. Other significant conditions	contributing to death but not resultir	ng in the un	derlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to t	the cause of death?
HECOLUS The law requires That been signated be 2 should be	ed by						_ 1_	Yes 2	No 3□ Pro	bably 4 □Unknown
law re las be	Completed			-			24a. Wa	s an opsy	24b. Were auto	opsy findings available
Bat I								formed?	death?	2 No
Or VITAL Physician: Tribis certificat	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		3□ DOA Oth		Death (Check only			
<u> </u>	n: To	27. Manner of Death	28a. Date of Injury 28	Outpatient Bb. Time of	3 □ DOA □ Our 28c. Injur Wor	4 🗀 Nursin				f(y)
ending ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation		Injury		k? Yes 2 □ No			2 YEARS 23d. Date of delivery Month Day Year 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify)	
or Attending frer death. Sirector: Afte in by the fune	Certification:	3 Suicide 6 Could not I 4 Homicide determined		e, farm, stre	et, factory, office		28f. Location City or To	(Street an own, State	d Number or Run	al Route Number,
spital ours a neral C		29a. Certifier 1 Certifying P	hysician: To the best of my knowle	edge, death	occurred at the tir	ne date and n	ace and due to the	e cancele	and manner as a	etatod
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	edical	(Check only 2 ☐ Medical Exa	miner: On the basis of examination and manner stated.	n and/or inv	estigation, in my o	pinion, death o	occurred at the time	, date and	d place, and due t	to the cause(s)
To the To the Complex	Ž	29b. Signature and title of certifier.	1/ks, Medical Actor		29c. License			29d. Dat	te signed (Month,	Day, Year)
1						3950		FEBRU	ARY 14	2009
10		30. Name and address of person who	completed cause of death (Item 23	Ba) (Type, F	Print)	00= 1.	ADVIALIN	212	21	
St	ate	ELIZABETH A. GRIFFITHS, M 31. Date filed (Month, Day, Year) FEB 17 2005	32. Registrar's Signature	PANAY	DACI IN	JILE M	TICT LAND	414	.31	
Regis	-4	FEB 1 7 2009	Deneda B. 1	gark						
DHMH 17 Rev 1/	2001		-							

Baltimore, Maryland 21215-0036

State Registrar

Medical

3 Suicide

29a. Certifier (check only

4 - Homicide

29b. Signature and title of certifier

Franscesca Miquel MD RES-000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

rebruary is 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Franscesca Miquei-Verges

6 Could not be determined

600 North Wolfe St, Baltimore, MD, 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year) 32. Begistrar's Signature FEB 18 2009

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 06531 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 0200 M Hilda SPRECHER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Coffman Nursing Home Hagerstown der 1 Year | If Under 24 Hrs. Washington 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 90 Director 219-07-2436 pril 30 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Wedical Even, not rivet by notified at 1√∑Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 Pangborn Blvd. Funeral 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc o. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: ۵ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Time Keeper Aircraft Mfo 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Vernon M. Miller Irene Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Guill Lane, Cottontown, Tn. 37048 <u> Harold T. Sprecher - Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 2/18/09 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Physician Muuti disease or condition resulting in death) /Medical Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed Exami and burial-trar Due to (or as a conseque) Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) P.O. ned by the a detached f 1 □Yes 2 4NG 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t lirector, page 2 s 24a Wasan 2 11Nn 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to me Be 26. Place of Death (Check only one) examine Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1₽ es 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how/injury occurred or Attending 1 Natural 5 Pending 200M) (le/2) 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2008 7 00 A 2 Accident investigation the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be **Bt. Location (Street and Number or Rural Route Number, City or Town, State)

Notion de Shilt Hige // Lun filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 0 4062 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **FEB 19** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 10a, b, c, e, f, per inf., g891,03/11,3709 dhb

Reg. No.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Februar ,20 **Physician** 2009 Ruth E. Stratton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Lanham Doctor's Community Hospital 9. Birthplace (State or Foreign Country) California If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sep. 7, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 X F Sep. 1921 87 556-20-3247 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10c. City, Town or Location 28a-f show traumatic event, I'm Medical Exa. i n.r. . ust be notified at MD 1 X Yes 2 ☐ No Director Prince George's Bowie **Virgnia** Alexandria 10g. Citizen of What Country? 10e. Street and Number 2400 Kemmerton Lane 10f. Zip Code 6 20715 USA 22314 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 XNo 3altimore, Maryland 21215-0036 Specify. 6 þ 3√Widowed 4 □ Divorced White "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Own Home 2+Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena E. Binford Rex J. Kirk 2 Department of Health and Important: If item 27 is ma any Injury or other trainments. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 3410 Moylan Drive Bowie, MD 20715 Robert Stratton/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/17/2009 Arlington, VA 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 aller 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 104 disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, and lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 known 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 2 10 1 Inpatient 2 FR/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Ž ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi 2009 ress of person who combleted cause of death (Item 23a) (Type, Print Burns 8118 Doll McK Road 8118

State Registrar

DHMH 17 Bev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Martha Jean Grisham Stocks 2009 4:00 P M Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Arnold FutureCare Chesapeake 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2**X** F 85 **Director** 426-34-8858 Feb. 12,1923 Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Anne Arundel Arnold Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
unt: If item 27 is marked other than "natural", or items 23a or 305 College Parkway USA 21012 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White Completed by Specify: 3 ₩ Widowed 4 Divorced er than "natur , the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Various Major Elementary/Secondary (0-12) College (1-4or 5+) Saleswoman Clothing Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wesley Grisham Julia Waters ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Stocks Graham/ Daughter 146 Charles Street Annapolis, MD 21401 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 12, National Memorial Park Falla Church, VA 2009 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Pyneral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** advanced disease or condition resulting in death) Cerebrovascu years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed the burial-trait Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ cate has been signi page 2 should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 ☐ Yes 1 ☐Yes 2 ☐No 2 🗓 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To the funeral 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 050725 erans they Millersville MD 21108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar
DHMH 17 Rev 1/2001

10.00	Bo	For State	ite of Maryland /	Certificate	of Death		Reg. Note of Death	0. 4) 0 9 0 6 5 3, Time of Death
Physiciar	1.	Decedent's Name (First, Middle				, N	nonth Day ebruary 12,	Year 2009	1806 hrs
l Examin	4:	Frank Add a. Facility Name (if not institution		npson	4b. City, Town, or I			4c. County of De	ath
		6304 Long Beach Roa	d		Port Republi		Date of Birth (A	Calvert	Birthplace (State or
uneral	5.	Social Security Number	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	Lleure Min	08/06/19	Foi	reign Country)Maryland
Director	L	213-40-7437	1 X M 2 F	65	Yrs.		36/00/1	943	
any,		sual Residence of Decedent Oa. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
	_	MD	Calvert	Port	Republic		1100	Citizen of What C	
farylar 28a-f		0e. Street and Number			10f. Zip Code		log.	U.S.	
within 72 hours after death with the Maryland jene. ric than "naturial", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral Director	6304 Long Bea	ach Road	Eurip IIC 13	2068. Was Decedent of His	nanic Origin? (Speci	fy Yes or No-	14. Race - A	merican Indian, Black,
th with	nera	Marital Status Never Married 2 Married	Armed Forces		If Yes, specify Cubar	, Mexican, Puerto Ric	an, etc:)	White, et	
er dea			/orced If Yes, Give Year	1	Yes 2X No			Specify:	white
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an "ns	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	er resear			U.S. Gov	ernment
withir giene. her th	E -	12 17. Father's Name (First, Middle	, Last)	Wat	er rebear	18.Mother's Name (F	irst, Middle, Mai	den Surname)	
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ould b d Meh s mar	의	19a. Informant's Name/Relations			lailing Address (Stre				
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es l ar of Hee If ite	1	1 Burial 2 X Crematio	n · 3 Removal from S	State Crematory	or other place) litan Crer	natory 02/	14/09	Alexand	ria, VA
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na injury or other traumatic event, the Medical Ex		4 Donation 5 Other S 24 Signature of Funeral Service	Specify: e Licensee		22. Name and Addres				
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hysician	7	23a. Part I. Enter the disease, of failure. List only one caus						t, SHOCK, OF HOUSE	Between Onset Death
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	<u> </u>	or condition resulting in death)	b.	isequelice oi).					
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law requires that the death certificate be executed law requires that the death certificate be executed has been signed by the attending physician and 2.2 should be detached for use as the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in		come of pregnancy	Fetal death	Ectopic pregnar	icy	Month	Day Yea
certif cending use as	iciar	past 12 months?	4 Pregnant	at time of death 5	Other (Specify)				
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COFC law re has be	Completed						perfor	111000	eath? Yes 2
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of VII ing Physic After this tuneral dir	-	27. Manner of Death	28a. Date of (Month, D	pay,Year)		njury at Work? Yes 2 ^X No	subjec	t fell	Su
	atio		rending Fd 2/	12/09 Fd of Injury - At home, far	6:U/ Pm		28f. Location (Street and Number	er or Rural Route Number Long Beach
ion of tending Phyeath. tor: After the funeral	ific	3 Suicide 6 C	could not be etermined (Specify)	Fd: resid	ence	o Banarrig, etc.	or Town, S Port R	epublic,	MD Beach
IVISION O Lor Attending after death. Director: Aft	1 +				th occurred at the time	e, date and place, and	due to the caus	e(s) and manner	as stated.
DIVISION Of VITAI RECORDS, sspiral or Attending Physician: The law require hours after death. meral Director: After this certificate has been si welled in by the funeral director, page 2 should b	Certification:	20a Certifier	Bhysician: To the best	of my knowledge, dea	til occarroa at the sim				
Division O the Hospital or Attending hin 24 hours after death. the Funeral Director: Aft notesty filled in by the fune		20a Certifier	g Physician: To the best of	examination and/or in	ivestigation, in my opi	lion, death occarros	at the time, date	•	
DIVISION Of VITAI RECOIDS, F.O. BOX 901 00, vitin 124 hours after death certificate be within 24 hours after death. To the Inospiral or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicial commission by the funeral director, page 2 should be detached for use as the burning the purity of the funeral director, page 2 should be detached for use as the burning.	Medical Cert	20a Certifier	Examiner: On the basis of and manner sta	examination and/or in	29c. Lic	ense number C.M.E.	at the time, date	•	ed (Month, Day, Year)

2009 32. Redistrar's Signature
ORIGINAL

State

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10 Pay FEB. 2009 11:39 NP JACKIE SPEIGHT 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville MONTGOMERY Casey House If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 1 □ M 2 ☑ F 158-52-8821 Apr. 13, 1959 49 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 7 Nancy Place, #6 20877 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 XNo 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed MD Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WESTAT Receptionist 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Buckman Carrie Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin 60e2 0 8 7 8 19a. Informant's Name/Relationship (Type. Print) 15705 Mahogany Circle #404, Gaithersburg Naketta Speight (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) All Souls Cemetery 2/14/09 Germantown, MD 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Breast Cancer disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Mode once.

Physician

/Medical

Examiner

Funeral

Director

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Baltimore, Maryland 21215-0036

ner Exami Physician/Medical ð Completed Be Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burtal-transit completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit

P.O. Box 68760.

Division of Vital Records.

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred **X**☐ Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier KOUNTCHOY, m)

20063748

29d. Date signed (Month, Day, Year) 2/11/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6601 Muncaster Mill Rd, Rockville, MD 20850 Jocelyne Kouatchou M.D.

State Registrar

Medical

Robert Brian Stock	S 1- For State Registrar	tate of Maryla	_	rtment of tificate of		nd Mental		20 Reg. No.	09 06536		
Physician/	Decedent's Name (First, Mid				· · · · · · · · · · · · · · · · · · ·		2. Date of De	eath Day Year	3. Time of Death		
Medical Examiner	Robert Brian 4a Facility Name (if not institut		imber)	4	o. City, Town, o	r Location of D		/ 16, 2009 4c County o			
The same of the sa	Calvert Memorial Ho				Prince Fre			Calvert			
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Ye		4Hrs. 8. Date of E	Birth (MM/DD/YYYY)			
Director	213-17-2658	1 X M 2 F	27	Yrs.	Months Da	ys Hours	10/1	0/1981	Country) Maryland		
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Baltimore, permit Pages I and Department of Heal Important: If iten injury or other tra	1 Burial 2 X Cremati	on 3 Removal f	rom State	crematory or oth	er place)						
timent Page or	4 Donation 5 Other 21 Signature of Funeral Service		Met	ropolitan	Cremato		2/22/2009	Alexandr eral Home, I			
Bal permi Depa Impo injur	De De	Ladin	: 0	P.	O. Box 60	0. Lusby	, MD 20657	eral Home, i	2.A.		
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Division of Vital Records, P.O. Bc tat or Attending Physician: The law requires that the desirs after death all Director: After this certificate has been signed by the a led in by the funeral director, page 2 should be detached for artification: To Be Completed by Physericans		ditions contributing	to death but not i	coulding in the c	nderlying occor	givorini					
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n of Vital I dding Physician: h : After this certif e funeral director. ion: To Be C	1 Yes 2 No	Hospital: 1	Inpatient 2		L		lursing Home 5	Residence 6			
n of N ding Phy h After tl funeral	27 Manner of Death 1 Natural 5 Pe	E Mom	e of Injury h. Day Year) , 2009	28b Time of I		jury at Work? Yes 2 ✔ N	Subject h	e how injury occurr anged self	ed		
Division ppital or Attent cours after death teral Director: filled in by the	2 Accident In	vestigation 28a Pla	ce of Injury - At h	ome, farm, stree				(Street and Numb	er or Rural Route Number, City		
Divisio spital or Atten hours after death neral Director filled in by the	3 Suicide 6 Co	ould not be	Single Far		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	J.	or Town				
		Physician: To the be	est of my knowled	lge, death occur	red at the time,	date and place	, and due to the ca	ause(s) and manner	as stated		
To the Hos within 24 h To the Fur completely	one) 2 Medical E	and manner	of examination a stated.	and/or investigat			rred at the time, da				
4	29b. Signature and title of cert	inter	1,			nse number C.M.E.		February 1	ed (Month, Day Year) 7. 2009		
	30. Name and address of pers	NVI. /CZ	use of death (Itan	n 23a)		Z. IVI. ←.			., 200		
DI WAS	/	eputy Chief Med			in Street, B	altimore, MI	D 21201				
State	the last last 1 is	32. F	Registrar's Signat	ure A	Med						

		Please Type or						-		_	•	
						rtment of F		i Mentai H	_	000) (10527
		1 - State Registrar Amended#31perFCHD 1. Decedent's Name (First, Middle, Last)				inouto or i	504(7)	2. Date of D		200	3.	Time of Death
Physici: /Medic		Mildred Beatrice	Scł	nulze				Februa		14 200		4:00 A M
Examin		4a. Facility Name (If not Institution, give street and no				4b. City, Town, or	Location of De	ath	4	c. County of D	eath	
<u> </u>		Angel Touch Assisted L					riendsh			Howar		
Funeral Director		5. Social Security Number 6. Sex 1 M 2 1 F	,	yrs. last birtl	hday) _ ′rs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		Day, Yea	r)	Birthplace Country) [ary]	(State or Foreign
D		Usual Residence of Decedent						pulle 1	<i>)</i> , 1	.920 F	агут	anu
irylane show	ايا	10a. State 10b. County	100	c. City, Town	or Loc	ation						nside City Limits
he Ma 28a-f	Director	Maryland Howard		Woodb	ine	T-101 7: 0 1		-	1.00	N		1 □ Yes 2 ☑ No
72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examinat be notified at		10e. Street and Number	1			10f. Zip Code	797			Citizen of What United		0.0
ms 23	Funeral	1685 St. Michael's Roa	edent Ever	in U.S.	13. W	as Decedent of H Yes, specify Cuba		(Specify Yes or N		14. Race - A		
or ite		Armed F 1 □ Never Married 2 ★ Married 1 □ Yes If Yes, G	2 🔀 No			Yes, specify Cuba □Yes 2⊠No	an, Mexican, Pu	erto Rican, etc.)		Black, W Specify: V	,	
ural",	d by	3 Widowed 4 Divorced Year or	Dates:									
"nati	lete	15. Decedent's Education (Specify only highest grade completed)	16a.	Decede (Give k	ent's Usual Occup ind of work done o O NOT use retired	ation during most of и	rorking	16b.	Kind of Busine	ss/Industr	у
withi	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)			omemaker	,			Own	Hom	e
e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last)		1			18. Mother's N	ame (First, Middl	e, Maide	en Surname)		
Menta Menta arked atic e	70 E	Simon Mills					Anna	Weillin	g			
2 sho		19a. Informant's Name/Relationship (Type. Print)				Address (Street						
1 and Health em 27		Albert V. Schulze / H				St. Mich		Date WOO	·	Location - City		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examination in the Intiliad at once.	ļ	1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from	State			ition (Name of atory or other place	1	ruary 2009	1	ederick		
artme ortan Injur	i	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	5	taurre		rematory Name and Addre						-
permi Depar Impor any Ir		I We alt	_			E. Ridge						
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. Let only one cause on	caused the each line.	death. Do n	ot ente	r the mode of dyir	ig, such as card	iac or respiratory	arrest,		Inte	oroximate erval Between
Physician		Immediate Cause (Final disease or condition	mas	stiv	e +	eart					Ons	set and Death
/Medical Examiner		resulting in death) Due to	(or as a	nsequence o	f):							Known
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uted d ansit	Examiner	Sequentially list conditions, if any head to transcribe cause. Enter Underlying Cause (Disease or injury that initiated events	(,	-7-							
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ш оо	Physician/Medical	d										
certific ding p	/Mec	IF FEMALE: 23c. If yes, or	itoomo of ni	roanonov								
atten for us	cian	in the past 12 menths?		Fetal death		Ectopic pregnanc Other (specify) _	у			23d. Date of Month	delivery Day	Year
the d by the	hysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown 9 ☐ Unk		0 01 000		Cutor (Specify)						
res that the death certificate bigned by the attending physic	by P	Part II. Other significant conditions contributing to	death but no	t resulting in	the un	derlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute	to the ca	use of death?
ne law require has been si ge 2 should b		Dementia						_ 1 [] Yes	2 No 3□	Probably	4 Unknown
law r has be	Completed							24a. Wa aut	opsy	prior	to comple	findings available tion of cause of
: The icate l	Co							per 1 □ Yes	formed?	death		lNo
siclar certif	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 Hospital: 1 ☐	11	0 T FD/0.4		Oth	or:	eath (Check only		a'Flau	ΔΔ	so at 0
g Phy er this eral d	n: To	27. Manner of Death 28a. Date	of Injury onth, Day, Ye.	2 ER/Out	ime of	28c. Injur		Home 5 ☐ Re			pecity)	35180cc
eath. or: Aft	atio	2 Accident investigation	ntn, Day, Ye	ar) III	ijury		Yes 2 □No					3
or Atter ter de irecto n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Plac build	e of Injury - ding, etc. (S	At home, far Specify)	m, stre	et, factory, office		28f. Location City or To	(Street own, Sta	and Number or ate)	Rural Roi	ute Number,
pltal o		29a. Certifier Certifying Physician: To the	a heat of m	, knowlodgo	dooth	popurred at the ti	mo data and ni	on and due to the		(a) and manna		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: On the										
To the within To the comp	Me	29b. Signature and title of certifier	1	/		29c. Licens	e number		29d. [Date signed (Mo	onth, Day,	Year)
6		> Unellia CSZ	land	Lin CA	NI	2 R	1075	159	7	1/16/	20	29
(10)		30. Name and address of person who completed cau	ise of death	(Item 23a) (Type, P	/			4	71	110	
		31. Date filed (Monta, Days Year) (2003) 32	Registrar's	Signature	2 6	7,121	nthic	icing 1	11) 21 , A. 4	09	0
Sta Registr		on sale med (marin, pay, real)	MAA	A	da	Med FF	B 1 7 20	09 Den	eus	B. A.	park	
		4			1111	1 to						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 06538 State
Registrar Amended#31perFCHD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day / 3 Month Year **Physician** Nicholas 0135AM 2009 e h /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 40n Hospital slum big Ge-ena If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours 1 X M 2 □ F 220-34-3070 69 **Director** March 26 1939 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified a once. 1 ☐ Yes 2 No Director Md. Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2140 Woodbine Road 21797 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1957-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 2 1960 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 County Government Firefighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Diehl Louis Sweadner Jeanette ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Juanita L. Sweadner / Wife 2140 Woodbine Road, Woodbine, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem. 2/17/09 4 □ Donation 5 □ Other (Specify) Alexandria, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home m-00470 Vna P. O. Box 5038, Laytonsville, Md. 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ischemic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Hospital of the former of the death of the attending physician and let filled in by the funeral director, page 2 should be death. Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an 12056951 2 No Chistoria 1 ☐ Yes brown c 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 →No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records,

Medical within 2 To the I

29a. Certifier

(Check only one)

29b. Signature and title of ceptifier

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) Day,

24 ess

and manner stated

			Ple	ease Type or P					_		-	
			For State	State of	Marylan		artment of H rtificate of	Health and N	Mental Hy		711114	06539
			State Registrar 1. Decedent's Name (First, Mic	ddle Last)			runcate of	Deam 	2. Date of De	Reg. No	2000	3. Time of Death
ш	Physicia		Elton F	Strev	ia Jr	•			Month	Da		0400 M
1	/Medic Examin		4a. Facility Name (If not institu		~		4b. City, Town, c	r Location of Death		40	. County of Deat	
me nick			Carroll Ho			l4 l- inth days	Westmi If Under 1 Year	nster	8. Date of Bi	rth	Carro	11 hplace (State or Foreign
	Funeral Director		5. Social Security Number 218-40-9032	2 6. Sex 1 ☑ M 2 ☐ F	7. Age <i>(In yrs.</i> 65	a <i>st birtna</i> ay) Yrs.	Months Days	Hours Min.	Sept.	a <i>y, Y</i> ea <i>r)</i>	Co	Maryland
	D		Usual Residence of Decedent						Dept.	1,	1745	
	arylan show	'n	10a. State 10b. Coul	•		y, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	MD Ca	arroll	W	estmi	nster 10f. Zip Code			10g. Ci	tizen of What Co	untry?
	n with	al Di	3515 Rineha	art Road				21158			usa	
	ems Seatl	Funeral	11. Marital Status	12. Was Deced		S. 13.	Was Decedent of I	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, If a Medical Examinar must be rediffed at	ð	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divord	farried 1 ☐ Yes	2 /≥ No e		1 □Yes 2 ☑ No	Specify:			Specify:	White
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212	filed within Hygiene. ther than	omp	Elementary/Secondary (0-12	2) College (1-	4or 5+)		intenan			R	ecreat	ion
bu	e filed al Hyg l other vent,	Be C	17. Father's Name (First, Midd	fle, Last)				18. Mother's Nam		e, Maidei		
yla	2 should be fi and Mental H is marked ot aumatic ever	입	Elton F.St						ed Mur	_		
Maryland	id 2 sh Ith and 27 is m		19a. Informant's Name/Relation	onship (Type. Print) evig, Wife				and Number or Ru art Rd.		-		Zip Code) D 211 58
re,	s t and 2 of Health item 27 i		20a. Method of Disposition		20b. F			ce)Cem.2/			ocation City or	
<u>m</u>	Pages I ment of I ant: If ite ury or ol		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other				ther Mi		20,00			
Baltimore,	permit. Pages Department of Important: If ii any Injury or once.		21. Signature of Funeral Serv	ice Licensee	.1, (1	2. Name and Addre		Manla	A	T # ± ± 1	17340
	0.0 = e 0	I	23a. Part 1. Enter the disease	or complications that ca	used the dea	7					· LIEUI	estown, PA Approximate
7	Physician		shock, or heart failure. I Immediate Cause (Final	List only one cause on ea	ich line.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (d	or as a conseq		ANTE	withou				
Ü	Examiner	<u>_</u>	Sequentially list conditions,	b	3101	m	Ar ten	1 0,00	30			Imo
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Supplied (c	or as a conseq	uence oi).						
oʻ	e execu an and rial-tra	Exa	that initiated events resulting in death) Last	CDue to (c	or as a conseq	uence of):						
9289	icate be executed physician and s the burial-transit	dical		d								
9 X	eath certific attending p for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna	ancy					23d. Date of de	livery
Box	death e atter d for u	iciar	in the past 12 months?	4 ☐ Pregn	irth 2☐ Feta ant at time of o		□ Ectopic pregnan □ Other <i>(specify)</i> _	су			Month	Day Year
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Records,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant cond	ditions contributing to de	ath but not res	uiting in the t	inderlying cause gr	ven in Part I.	1	,		o the cause of death?
eco	law require as been si 2 should b	Completed							24a. Wa	DDSV	prior to	utopsy findings available completion of cause of
<u> </u>	: The law cate has by page 2 s	Com							per 1 □ Yes	formed?	death? o 1 ☐ Yes	2 □ No
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to med examiner?	Hospital:		,	_ 0t	26. Place of Dea				
of	Phys er this eral dir	. To	1 Yes 2 No 27. Manger of Death	28a. Date o	of Injury	28b. Time of	III 3 DOA	4 LI Nursing H	ome 5 Res		6 ☐ Other (Spe	cify)
<u>io</u>	nding Phy ath. r: After thi ie funeral o	atior	1 Natural 5 ☐ Per 2 ☐ Accident inve	nding (Monti estigation	h, Day, Year)	Injury		rk?]Yes 2 □ No				
Division	Il or Attendi after death. I Director: A d in by the fu	Certification:		uld not be ermined 28e. Place building	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location Cify or To	(Street a	nd Number or R e)	ural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifier 2 Medi	ifying Physician: To the cal Examiner: On the ba and mann	sis of examina	owledge, dea ation and/or i	th occurred at the investigation, in my	time, date and place opinion, death occu	e, and due to th	e cause(e, date ar	s) and manner a nd place, and due	s stated. e to the cause(s)
	To the virthii To the comp	Me	29b. Signature and title of cer	tifier	0 1	1	29c. Licen	se number		29d. D	ate signed (Moni	h, Day, Year)
	WIL		Kimb	erly U do	myl	W	DOC	75549	ď	d	1-13-	04
_	4		30. Name and address of pers	A. JOHNS	TON	444		DRIVE S	STE IL	4	MARYLE	MINSTER ND 21158
	Sta Registi		31. Date filed (Month, Day, Ye	1 7 2009 32. Re	gistrar's Signa	A. A.	barres					
						7.4						

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Anna Virginia Snyder Feb. 13, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Center for Hospice Care Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 7/6/1919 MD Director <u>213-10-7493</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Exemples must be a willed at 1 ☐ Yes 2 ☑ No Director MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14630 Hanover Pike 21155 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify.white ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home 11 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Kelly William A. Richardson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14630 Hanover Pike, Upperco, Md. 21155 Alvin R. Snyder, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 2/18/2009 Sykesville, Md. 22. Name and Address of Facility 21. Signature of Funeral Service License Eline Funeral Home M00741 Thouse Lenner 934 South Main St., Hampstead, Md. 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SMALL BOWEL OBSTRUCTION WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): YEARS Examiner ASTRIC CARCINOMA Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a Division of Vital Records, P.O. 9 D Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐Yes 2 No To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D64395 WIL PEBRUARY 13,2009 30. Name and address of person who completed cause or death (Item 23a) (Type, Print) 6565 N CHARLES ST, SMITE 209 BALTIMORE, MD 21204 DOBERMANI MP DANIGUE 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB Eleven Registrar

Division of Vital Records, P.O. Box 68760,

		For	Plea	se Type or I State of		nd / Dep	artment	of Health	and M	-		•		
		- State Registrar				Ce	rtificate	of Death	1	F	Reg. No	200	9	0654
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/Medic		Ada Flo					_			Februar	ry 1	1, 2009		5:15 A ^M
Examin	er			n, give street and nur				own, or Location	of Death			County of Dea	ath	
				Memorial			Oakla If Under 1		r 24 Hrs.			arrett		
Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🔀 F	7. Age (In yr	s. last birthday,		Days Hours		Date of Birt (Month, Day	/, Year)	C	ountry)	(State or Foreign
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yland Now		10a. State	10b. County		10c. (City, Town or Le	ocation				***		10d. lr	nside City Limits
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n 72	lete			t's Education st grade completed)		16a. Dece	edent's Usual (Occupation done during mo retired)	st of worki	ng	16b. K	ind of Business	/Industry	/
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filed I Hyg other ent,	Be C	17. Father's Name	(First, Middle,	Last)				18. Moth	ner's Name	(First, Middle,				
ld be lenta ked ked	To B	Clarenc	e Davis	5				Jess	ie Lo	oughry				
shou and N a mar		19a. Informant's N	lame/Relations	hip (Type. Print)		19b. Maili	ing Address (5	Street and Numl			r, City o	or Town, State,	Zip Cod	'e)
alth a		Timothy	R. Sav	age/Son		2096	White	Rock Ro	l., Fr	ciendsv:	ille	, MD 2	2153	1
permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, I'm Medical Evaniting in 11 and 000ce.		20a. Method of Dis		_		. Place of Disp	osition (Name matory or other	of er place)	D	ate	20c. L	ocation - City or	Town, S	State
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		23 Par 1. Ent ar	the disease, or	o in plications that ca	aused the de	ath. Do not en	iter the mode	of dying, such a	s cardiac c	or respiratory ar	rest,		App	roximate rval Between
Physician	8 4	Immediate Cause	(Final	t the cause on ea	acii iliie.	۲	Ham	- 10,	. 1	C-)	0.0			set and Death
/Medical		resulting in death)		Due to (or as a conse	equence of):		nu la	m	FOV	lon		-	41/2
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Attending Physician: The law requires that the death certificate is reach. ector: After this certificate has been signed by the attending physis by the funeral director, page 2 should be detached for use as the b	Me	IF FEMALE:												
ath c	ian/	23b. Was deceder in the past 12			oirth 2 🗆 Fe	etal death 3	Ectopic pre					23d. Date of de Month	elivery Day	Year
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e law has l	훁									24a. Was a autop	sy	prior to	utopsy fi complet	indings available tion of cause of
r: Th icate ; pag	8									perfor 1 □Yes	med? 2 No	death?	s 2 🗆	No
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after Dire	ertii	4 Homicide	determ	buildir	ng, etc. (Spe	home, farm, st cify)	, 1401019, 0	Miloc	'	City or Tow	n, State)	urai nou	ne rvaniber,
spita ours neral		29a. Certifier	1⊡ Certifyin	ng P hysician : To the	best of my k	nowledge, dea	th occurred at	the time, date a	and place.	and due to the	cause(s	and manner a	s stated	
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	2☐ Medical	Examiner: On the ba	asis of exami	nation and/or i	nvestigation, in	n my opinion, de	eath occurr	ed at the time,	date an	d place, and du	e to the	cause(s)
ro the rough within rough	Me	29b. Signature and	title of certifie	. 0			29c. l	License number			29d. Da	te signed (Mon	th, Day,	Year)
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,		30. Name and add	lress of person	who completed caus	e of death (It	em 23a) (Type.	, Print)					1		
				, 311 N.	Fourth	St.,	Dakland	, MD 2	1550					
Sta	te	31. Date filed (Mor	nth, Day, Year)	0000 32. P	egistrar's Sig	nature	mekel	., 2						
Registr	ar		FEB 17	2009	MINA.	1. 19	1 (20.00)							

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	te of Maryla		artmen r <i>tificat</i>					JIENE eg. No.	Z 1111	9	06542
			Decedent's Name (First, Middle, Last)							Date of Dea	th			3. Time of Death
	Physicia /Medic		Matilda Marie Smear	man					Fe	Month ebruar	y 6,	, 200	5 ar	8:42 AM
1	Examin		4a. Facility Name (If not institution, give street a			,,		Location	of Death			County of		
-2			Oakland Nursing & Reh			er If Under	Oakl		24 Hrs. 8.	Date of Birth		arret		ace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2		s. last birthday) 77 Yrs.	Months	Days	Hours	Min. Ar	(Month, Day	Year)	931 F	Count	sylvania
			Usual Residence of Decedent						[- - -					
	how how	_	10a. State 10b. County	10c. C	City, Town or Lo	cation							10	d. Inside City Limits 1 ☐ Yes 2 🕱 No
	Ba-f s	Director	MD Garrett	Fr	iendsvi	_						4148		
	vith th		10e. Street and Number	pa		10f. Zip	Code 1531				USA	zen of Wha	at Count	ry?
	s 23a	Funeral	3740 Friendsville-Add	s Decedent Ever in	US 13				rigin? (Specify			14. Race -	America	an Indian.
10	ter de	F	1 □ Never Married 2 □ Married 1 □	ned Forces?]Yes 2⊠No		_			rigin? (Specify n, Puerto Ric	an, etc.)			White, e	
036	urs af	þ	If Y	es, Give ar or Dates:		1 □Yes	² X No	Specify:				Specify:	Whi	te
21215-0036	be filed within 72 hours after death with the Maryland rital Hygliene. ed other than "natural", or Items 23a or 28a-f show event, if a Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	eleted)	16a. Dece	dent's Usu kind of wo	al Occup rk done d	ation during mos	st of working		16b. Ki	nd of Busir	ness/Ind	ustry
121	within iene.	dm	Elementary/Secondary (0-12) Co	lege (1-4or 5+)			se retirea	()			Ot.71	n Hom	_	
	filed w Hygie other t		8 17. Father's Name (First, Middle, Last)		Homem	aker		18. Moth	er's Name (F	irst, Middle,				
and	thould be filed and Mental Hygi marked other matic event, il	o Be	Isaac Prinkey					Bess	sie Mu	rray				
Maryland	s 1 and 2 should be f Health and Mental tem 27 Is marked o other traumatic eve	ဥ	19a. Informant's Name/Relationship (Type. Pri	nt)					er or Rural R					
	27 In		Sarah Meyers/Granddau	ghter	391 H	umber	son	Rd.,	Frien	dsvill	e, l	MD 2	1531	-
altimore,	000		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remova	20b.	Place of Dispo cemetery, crei	sition (Name	me of other plac		Date			ocation - Ci	•	
Ë	Pages ment of ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	Ac	dison (eb. 11					
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee						ity Newm Grants					P.A.
_	<u>v</u> □ = # 0			man	1							213	50	Approximate
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	se on each line.	ath. Do not en	ter the mod	ge of dyln	ig, such as	s cardiac or re	espiratory an	est,			Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	M >) A Oue to (or as a conse	50	, , , ,							-	weeks
7	Examiner			M SSA	equence oi).	lens	lab	score	-					weeks
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a const										
	ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events c.		myron	nsey	(years
8	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):	4	5/1	1.1.	. with	ms	54			
68760,	physic the b	edical	d. <u>2</u>	steomy	/I \$P \) us.	- ma	- 47 0					
_	Physician: The law requires that the death certificate be executed riths certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	/Me		es, outcome of preg								23d. Date	of delive	ry
Box	death atter	iciar	in the past 12 months?	☐ Live birth 2 ☐ Fe ☐ Pregnant at time o		□ Ectopic (□ Other <i>(s</i>		У				Month	n	Day Year
P.O.	res that the de signed by the a be detached f	Physician/M	9 Unknown 9L	Unknown										
	ss tha gned se det	by P	Part II. Other significant conditions contribution	ng to death but not re	esulting in the u	inderlying	ause giv	en in Part	I.			le .		e cause of death?
Records,	e law require has been si ge 2 should b	ted	CHI SULL THE	2 15100	1- my	1/1	0100	-1 C		1 🗆 Y	es 2	No 3	☐ Prob	ably 4 ☐ Unknown
ec	law l has b	Completed	CATI, CHI-, OST	50 mil!	55, 17	120				24a. Was a autop		prie	ere autop or to cor ath?	osy findings available npletion of cause of
프	Iclan: The certificate ector, pag									1 □Yes	2 No		Yes	2 / ⊴No
Vital	sician certif rector	Be	25. Was case referred to medical examiner?	di	T 52/0 11		Oth		e of Death (C			6	(0 : 6	
of	Phys rr this eral di	<u>ان</u>	I Tes 2 100	Date of Injury	☐ ER/Outpatie 28b. Time o		28c. Iniur	v at	lursing Home	Describe h				/)
on	nding Fith.: After	tior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	lnjury	М	Wor 1 □	k? Yes 2□]No					
Division	Atter	iffica	a □ autota 6 □ Could not be	e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factor	y, office		28f	Location (S City or Tow			or Rura	I Route Number,
Ö	ital or rs after al Dir led in	Certification:												
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician 2 Medical Examiner: C	on the basis of exami	knowledge, dea ination and/or i	th occurred nvestigatio	d at the ti n, in my c	me, date a opinion, de	and place, an eath occurred	d due to the at the time,	cause(s date and	s) and man d place, an	ner as s d due to	tated. the cause(s)
	the I	Medical	29b. Signature and title of certifier	nd manner stated.		29	c. Licens	e number			29d. Da	ite signed_(Month, i	Day, Year)
	Z × Z 0		· MILL-MA	M			0064				2	16/0	39	
		1	30. Name and address of person who complet	ed cause of death (II	tem 23a) (Type		W04	105					•	

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

Richard A. Porter, 311 N. Fourth St., Oakland, MD
31. Date filed (Month, Day, Year)
32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:15 P M 2009 February 4, Sanders W. /Medical Harvey 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett Garrett County Memorial Hospital 0akland Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Min. 1X M 2□ F Months Days 1913 West Virginia Director 212-10-7993 95 June 11, Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD Garrett 0akland 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 21550 United States 445 Dennett Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 □ Yes 2X No If Yes, Give Year or Dates Specify Completed by Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Dealership Owner .. Pages 1 and 2 should be filed wi tment of Health and Mental Hygier tant: If Item 27 Is marked other th Jury or other traumatic event, Its 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lula Grimes Austin P. Sanders ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 237 Astor Circle, Terra Alta, WV Phyllis Teets, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2009 Oakland, MD Oakland Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21550 Ratherne Sweets 21 N. Second St., Oakland, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final no unow 14 Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical as the Box (IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the at the detached for 5 Other (specify) I □Yes 2 □ No Ö 9 ☐ Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this ot To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral: 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide (X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number Feb. 5, 2009 D23979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Goralski, MD 311 N. 4th St., Oakland, MD 21550 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar FEB - 9

State of Maryland / Department of Health and Mental Hygiene. 06544 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician $\overset{\mathsf{Day}}{1}0$ FEBRUARY 2009 12:12 P M BEATRICE SNOWDEN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine PRINCE GEORGE'S 9761 GOODLUCK ROAD LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Months Days Hours Min **Director** <u>579-48-6309</u> AUG 1931 MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S LANHAM 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 9761 GOOD LUCK ROAD # 20706 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò ğ 1 ☐Yes 2 📉 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER SPECIALIST YR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RALPH W. SNOWDEN ၉ SUSIE BARNS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET ODOMS/COUSIN 3016 SAVANNAH WAY # 206 MELBOURNE, FL 32935-3639 other If Item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) HARMONY CEMETERY 2/16/2009 LANDOVER, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DIABETES MELLITUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNCONTROLLED HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit HIGH CHOLESTEROL and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate of Vital 1 ☐ Yes 2 🙀 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) Hospital: ٩ 1∏Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 1 X Natural 5 Pending spital or Attendiours after death.
neral Director: / death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063558 FEBRUARY 17 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 1221 MERCANTILE LANE UPPER MARLBORO, MARYLAND MELISANDE SMITH M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State	of Mar	yland / De	partmen Certificat			and M		giene Reg. No. 2	009	06	545
	Physici	an	1. Decedent's Name (First, Midd Abragail C								2. Date of De Month Februa:		Year	3. Time of 5:30	of Death A M
100	/Medio Examin		4a. Facility Name (If not instituti Manor Care					Town, o	r Location o	of Death	1 COT CO.	4c. Cou	nty of Death		A
	Funeral Director		5. Social Security Number 579–46–3664	6. Sex 1 ☐ M 2 X F		In yrs. last birtho	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da April	h y, _{Year)} 9, 193	Cou	place (State ntry) shingto	
	e Maryland 3a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. Coun MD Prin	y ce George		Oc. City, Town o	r Location								City Limits s 2 □ No
	with th		10e. Street and Number				10f. Zip		721			10g. Citizen	of What Cou SA	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M. dical Examiner must be notified at once.	by Funeral	721 St. Mid 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was D Armed 1 □ Ye	ecedent Ev Forces? es 2 No	er in U.S.	13. Was Deced If Yes, spe	dent of H			ecify Yes or No Rican, etc.)	- 14. F	Race - Ameri Black, White, ecify: Bla	etc.	
1215-0	within 72 ho sne. than "natu ne M dical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade complete Colleg	ed) e (1-4or 5+) YS •	(S	ecedent's Usua Give kind of wo fe. DO NOT us Licen	rk done se retire	during mos d)		ing	16b. Kind o	f Business/In	,	
Maryland 21215-0036	uld be filed the filed the filed the filed the filed other file event, the file event file	To Be Co	17. Father's Name (First, Middle Daniel Cea	e, Last)					18. Mothe	er's Name	e (First, Middle, 1 Jackso			V C.	
	s 1 and 2 shou f Health and M fem 27 Is mai		19a. Informant's Name/Relation Jacqueline Se. 20a. Method of Disposition	llers/ da		r 6	608 63r	d Pl	. Sea	t Pl	easant Date	MD 2	wn, State, Zij 20743 on - City or T		
Baltimore,	rt. Pages rtment of I rtant: If Ite		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other	Specify)	om State	Chesape	ake Cr	emat	ory	-	2009		sville		
Ba	Dermi Depa Impo any II		21. Signaturd of Funeral Servic 23a. Part1. Enter the disease, shock, or heart failure. Li	nax.	Pil	Land Do not	9908 S	assa	fras_	Lane	lgen Fur Mitche	llvill	Servic e, MD	e, PA 2072 Approxima	
68760,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-fransit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due	to (or as a construction (or as a constructi	estive H consequence of) re Pulmo consequence of) nic Obst consequence of) Venous	leart Fa	ailu yper e Pu	re tensi lmona	on ry D	isease			Interval Be Onset and	Death
Vital Records, P.O. Box 6	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	by Physician/Med	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Liv 4 □ Pr		pregnancy □ Fetal death me of death	3 □Ectopic pi 5 □ Other (sp		у				Date of deliv Month	very Day	Year
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al Reco	2 28	Completed									24a. Was autop perfo 1 Yes		b. Were auto prior to co death? 1 ☐ Yes	opsy findings ompletion of 2 \bigsilon No	available cause of
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Division or	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	28a. Da ling (A tigation	ate of Injury Nonth, Day	28b. Tim		28c. Injui Woi			28d. Describe I				
<u>Š</u>	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:	4 Hornicide	mined 28e. P)	uilding, etc.						28f. Location (8 City or Tox	vn, State)			nber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	(Check only 2 Medic		the best of le basis of e nanner state	examination and/o	or investigation	n, in my	opinion, dea	nd place, ath occur	and due to the rred at the time,	date and pla	ce, and due t	to the cause	(s)
	Vith To 1	Σ	29b. Signature and title of certi	ier	,	MD			e number			29d. Date sig	ned (Month,		
R	7		30. Name and address of person Meklit Work	n who completed c	ause of dea		pe, Print)		2116 belt,	MD	20770	ચ (1	+103		
2	Sta Regist		31. Date filed (Month, Day, Yea FEB 1 8 2009	r) 3:	Registrar'	's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06546 Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 Elva Selena Van Schaik epruare /Medical 4b. City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Hospital aston albo If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, March 23, 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Vear 1 ☐ M 2 🖫 F Director 216-40-2636 67 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Funeral Director Maryland Caroline Denton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 8571 Briar Patch Drive 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: Caucasian Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eveonce. Elizabeth Virginia Masten ၉ Donald MacDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8571 Briar Patch Drive, Denton, Maryland 21629 Husband Richard Van Schaik timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 2/24/2009 Denton Ce m etery Denton, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Complete HEART disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Caedine Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed use as the burial-transit SARCOIDEST and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part Lother significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tophe VALUE & AORKZ 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature a

DHMH 17 Rev 1/2001

State Registrar 2160

EAST

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Idlewild AVE

31. Date filed (Month, Day, Year)

Registrar DHMH 16 Rev 6/95

Physician

/Medical

Examiner

Director

Funeral

Completed

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permit. Pages 1 end 2 should be tiled within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

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attanding physicien and I for use es the burial-transit

within 24 hours eftar death.

To the Funeral Director; After this certific completely filled in by the funarel director.

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Hospital or Attending

To the

Division of Vital Records, P.O. Box 68760.

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32. Registrar's Signature

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32. Registrar's Signature

			1 - For State Registrar	State of Mary		tificate of L		ı	Reg. No. 2	009		549
	Physicia /Medic		Decedent's Name (First, Middle, Last, DeLinda	Lee	Sh	umaker]	2. Date of Dea Month Februar	Day	Year 2009	3. Time of 11:10	
>	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or				inty of Death		
		35	11 W. Baltimore St 5. Social Security Number 6. Se		yrs. last birthday)	Hagersto	If Under 24 Hrs.	8. Date of Birt		hingto	n lace (State o	r Foreign
Ato .	Funeral Director			M 2⊠F 64	Yrs.	Months Days	Hours Min.	(Month, Day March 2	y, Year)	Coun	try)	
	yland now at		10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside Cit	y Limits
	death with the Maryland rms 23a or 28a-f show r must be notified at	Director	MD Washingt	on	Hagersto	own					1 X Yes	2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?	
	eath v	era	11 W. Baltimore St	t. Apt.231 12. Was Decedent Ever	in U.S. 13. V	21740 Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spe	cifv Yes or No-		J.S.A. Race - Americ	an Indian,	
136	be filed within 72 hours after death with the Marylan ital Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cubai □ Yes 2 No		Rićan, etc.)		Black, White, on the second with the second wi		
12-0036	72 hou natura iical E		15. Decedent's Edu (Specify only highest grad	cation	16a. Deced	lent's Usual Occupa	ation Jurina most of workin	na I	16b. Kind o	f Business/Ind	dustry	
	vithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done d DO NOT use retired) Speciali		.9	Banki	ng		
7 0	filed v Hygie ther t	S	12 17. Father's Name (First, Middle, Last)		Traud	···-	18. Mother's Name	(First, Middle,				
_	lid be lenta ked o ic eve	o Be	Samuel Harrison C	ooper, Jr.			Virginia	Kather	ine Sa	avory		
Mary	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Mailin	g Address (Street a	and Number or Rura	I Route Numbe	er, City or To	wn, State, Zip	Code)	
χ. Σ	and 2 lealth m 27 i		Edward E. Shumake	r, Sr./Husb	and 11 W.	Baltimo	re St. Ap	t. 231,	Hage	rstown.	MD :	21740
Baitimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, cren	natory or other place	e) ¦			on - City or To	,	
	nit. Partmer artmer ortant injury	V	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			n Cemeter . Name and Addres				stown,		
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.	(2)	I S. Mull Su	m		01 Pennsy					^	42
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	il ations that caused the necause on each line. a. HTOTL, Due to (or as a co	acion	er the mode of dying	g, such as cardiac o	r respiratory ar	rest,	/	Approximate Interval Bety Onset and E 2 H y	ween
	sit sd	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or injury	Due to (or as a co	nsequence of):					10		
68760,	ifficate be executed g physician and as the burial-transit	cal Examiner	Catase (Disease of Injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):							
Box 68	ii Dig	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr	Fetal death 3	Ectopic pregnancy			23d.	Date of delive	*	/ear
o.	the de y the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e or death 5L	Other (specify)						
7	w requires that the death cen been signed by the attendin should be detached for use		Part II. Other significant conditions co		ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did to		ontribute to th	ne cause of d	
vital Records,	The law req te has beer age 2 shou	Completed by						24a. Was autop	SV /	4b. Were auto prior to cor death?	psy findings a	available ause of
<u></u>			25. Was case referred to medical				00 Plant (Part)		rmed. 2 No	1 ☐ Yes	2□No	
	ysicia s cert directo	o Be	examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	t 3 DOA Othe	26. Place of Death er: 4 □ Nursing Hor			Other (Specifi	/}	
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UIVISION	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	eet, factory, office	2	28f. Location (S City or Tow	Street and Nu vn, State)	ımber or Rura	l Route Num	ber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Fun ral Director After this certifical completely illed in by the funeral director,	ledical C		sician: To the best of my iner: On the basis of exa and manner stated.	amination and/or in)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License			29d. Date siç	gned (Month,		
}			1 Ch 1623				22313			8-6	13-09	
			30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type, HAG	Print) ENCTOUS	1 .60	21	392			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrary 3 2009	Signature A.	Barke	r					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 9, Рм 2009 9:10 FEBRUARY STEPCHUCK MICHELE M. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) CECIL 157 KIRKCALDY DRIVE ELKTON If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 1 □ M 2 X F 222-42-7776 54 JUNE 25, 1954 NEW YORK Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No MD CECIL ELKTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21921 UNITED STATES 157 KIRKCALDY DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ₺ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECHNICAL ANALYST BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARION LEWANDOWSKI HAROLD ENGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JR/HISRAND 157 KIRKCALDY DR. ELKTON, MD 21921 CURTIS E. REEDY, 20b. Place of Disposition (Name of cemetery, crematory or other place)
EBENEZER U.M.C.
CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 2/14/2009 NEWARK, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
SPICER-MULLIKIN FUNERAL HOMES,
1000 N DUPONT PKY NEW CASTLE, 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1□Live birth 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ ✓ 0 24a. Was an autopsy performed? Yes 20 No 2 💢 26. Place of Death (Check only one) Other: 4 Nursing Home Statement 6 Other (Specify) 201 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Physician /Medical Examiner the death certificate be executed and burial-tra the attending pl page 2 s has

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Hospital or Attending

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

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If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or iter any injury or other traumatic event the Madical

death with the Maryland

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Maryland

Baltimore,

Examiner Physician/Medical Be Completed by Certification: To funeral ithin 24 hours after death.

the Funeral Director; A

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 27. Manner of Death 1 Natural
2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

aven

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2 Katharine Ernestine Studz 2009 5:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Catered Living at Ocean Pines Ocean Pines Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X □ F 100 212-09-2515 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Director MD Worcester Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13620 Alliston Dr. 21013 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: ģ Specify. 3 XWidowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Water and Power Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lotz Mary Frohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21842 Carole Miller / daughter 12801 Wight St., Dune House #18, Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/17/2009 Cape Henlopen Crem. 5 Other (Specify) Frankford, DE 4 □ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 disease, or complete one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Examiner ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ate has page 2 s 1∏ Yes To the Hospital or Attending Physician: ours after death.

neral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: AN Nursing Home P 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month. Dav. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print), BA 6 Constal Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 7 2009 Registrar

Division or Vital Records, P.O. Box 68760.

State Registrar DHMH 17 Rev 1/2001 itle of certifier

nnu

29b. Signature ape

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06554 Reg. N2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Abraham Isaac TERSOFF February 2009 8:45 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7505 Democracy Blvd., #325 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months New York 130-22-9201 82 May 20, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery Bethesda 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code 20817 7505 Democracy Blvd., #325 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in O.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Engineer U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Morris Tersoff Yetta Pollack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janet Tersoff, Daughter 1528 Foxhall Road, NW, Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 02/15/09 Olney, MD 21. Signature of Fureign Service Licensee Torchinsky Hebrew Funeral Home 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final) 20012 Approximate Interval Between Immediate Cause (Final 19 rear Peath Parkinson's Disease disease or condition resulting in death) Due to (or as a consequence of): Lewy Body Disease 5 Years Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Completed

Be

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Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the "modeal Evan incornest be notified at

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within 72 hours after

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permit. Pages 1 and 2 should be fill Department of Health and Mental I Important: If Item 27 Is marked ott any Injury or other traumatic even

Baltimore, Maryland 21215-0036

Exami Physician/Medical ģ

attending physician for use es the burial Completed Certification: To Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit

Division of Vital Records, P.O. Box 68760.

10+1

Prostate Cance	Υ	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Non-Hodgkin's	Lymphoma	24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 X Residence 6 □ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	n (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	3d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in the cause of examination and or investigation in the cause of examiners. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature 29c. License number

D 29229

29d. Date signed (Month, Day, Year) 02/12/09

completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Ave., #750, Chevy Chase, MD 20815 Martin Kanovsky, M.D.,

State Registrar

Medical

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate be exe

	State Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of L	Death	Reg	. No. 2	09	065	55
an	Gilbert William Thompson, Sr.				Month February	Day 14.	Year 2009	8:32	Deatr
cal ner	4a. Facility Name (If not institution, give street and number)	•	4b. City, Town, or	Location of Death	1 CDI dai y		y of Death		
	9524 Mary Road		Berlin,				ester		
	5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) 2/17/1	^(ear) 2	Coul	olace (State o ntry) ington	
	Usual Residence of Decedent	O- City T							
ō	Maryland Worcester	Dc. City, Town or Lo Berlin	cation					0d. Inside Cit	1
Director	10e. Street and Number	DELLIII	10f. Zip Code		100	j. Citizen of	What Cour	ntry?	
a D	9524 Mary Road		2181	1		USA			
Funeral	11. Marital Status 12. Was Decedent Eve Armed Forces?	r in U.S. 13.1	Was Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ		
by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Sire Sire Sire Yes, Give Year or Dates:	945	1 □Yes 2 🕻 No	Specify:		Spec		ite	
ted	15. Decedent's Education		dent's Usual Occupa		16	ib. Kind of E	Business/In	dustry	
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	'life. I	kind of work done d DO NOT use retired,	uring most of worki)	ng				
	11	Farme	1	40 Mashada Nasa		Farmi			
Be	17. Father's Name (First, Middle, Last) William Kendall Thompson			18. Mother's Name	Bradfor		me)		
ဠ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a				n, State, Zip	Code)	
	Mary Thompson / wife	9524	Mary Road	d, Berlin	, MD 218	11	·		
	1 N Rurial 2 Cramation 2 D Romanal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place	; [c. Location	- City or To	wn, State	
	4 Donation 5 Other (Specify)		Cemetery		/2009	Berli	n, MD		
	21. Signature of Juneral Solvice Licensee	- 1	2. Name and Addres	Bur	bage Fun t, Berli	eral I	lome 2181	1	
	23a. Part1. Enter the dial se, or o implications that caused shock, or heart failure. List only one cause on each line.	e death. Do not ent	ter the mode of dying	g, such as cardiac o	or respiratory arres	t,		Approximate Interval Bet Onset and D	ween
	Immediate Cause (Final disease or condition resulting in death)		VAL F						Jean
	Due to (or as a co	onsequence of):	HPERTO	= 4000	\				
je.	Sequentially list conditions, if any, leading to insured atte		111 210 10	210310					
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
a Ex	resulting in death) Last Due to (or as a co	onsequence of):						_	
	d								
Physician/Medio	IF FEMALE: 23c. If yes, outcome of p	pregnancy			1011	334 D	ate of deliv	on.	
iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tin		☐ Ectopic pregnancy ☐ Other <i>(sp</i> ec <i>ify)</i>	,			lonth	•	⁄e ar
hys	9 Unknown								
by	Part II. Other significant conditions contributing to death but n	ot resulting in the u	nderlying cause give	n in Part I.	23e. Did toba		ntribute to t	he cause of d	eath'
Completed		, , · ,			1 🗆 Yes	2 No	3 ☐ Proi	bably 4∏ U	Jnkn
					24a. Was an autopsy	- 1	prior to co	psy findings ampletion of ca	availa ause
				_	performe 1 □ Yes 2	ZNo	death? 1 ☐ Yes	2 □ No	
Pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	0 □ EB/O + 1:	Othe	26. Place of Death					
=	27. Manner of Death 28a. Date of Injury	28b. Time o	M 3 L DOA	4 □ Nursing Ho	me 5 Residen			fy)	
atio	Natural 5 ☐ Pending (Month, Day, Yo 2 ☐ Accident investigation	ear) Injury		? /es 2 □ No					
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (- At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,		ber or Rura	al Route Num	ber,
Medical	29a. Certifier (Check only one) Certifying Physician: To the best of n 2 Medical Examiner: On the basis of examiner and manner stated	ramination and/or in	h occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and r e and place	nanner as s , and due t	stated. o the cause(s)
Me	29b. Signature and title of certifier		29c. License	number	290	I. Date sign	ed (Month,	Day, Year)	
	1 Step la Work	- wo	0.	2799	3	7	-17-	09	
ŀ	30. Name and address of person who completed cause of death	h (Item 23a) (Type,							
	Dtephen Waters 1001 Philado 31. Date filed (Month, Day, Year) 32. Registrar's	elphia Av Signature	e., Ocean	City, M	21842				

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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		State of r	viarytano		artment of r rtificate of		ia ivien		ene 0	09	06556
			1. Decedent's Name	e (First, Middle, La	st)						ate of Deat	h	Vaar	3. Time of Death
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					emorial H	ospital		0akland				Garr	ett	
в	Funeral		5. Social Security N		I M 2 TF	Age (In yrs. la:		If Under 1 Year Months Days	If Under 24 Hours		ate of Birth Month, Day,	Year)	9. Birth	place (State or Foreign intry)
	Director		220-44-8 Usual Residence of	56/		93	Yrs.			Dec	2. 4,	1915	Wes	t Virginia
	tand ow		10a. State	10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Many	ţō	MD	Garrett		Kit	zmil]	ler						1∏Yes 2□No
	r 28a	Director	10e. Street and Nur	mber				10f. Zip Code			1	0g. Citizen	of What Cou	intry?
	h witi		239 E. M	ain Stree	et			21538				Unite	d Sta	tes
	dee	Funerai	11. Marital Status		12. Was Deceder Armed Force	nt Ever in U.S.	. 13.	Was Decedent of H	Hispanic Origin	n? (Specify	Yes or No-		Race - Amer Black, White	
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. By other then "neturel", or Iteme 23a or 28a-f ehow event, it a Medical Examinar must be notified at	þ	1 ☐ Never Marri 3 🎇 Widowed	ied 2 Married 4 Divorced	1 Yes 2 If Yes, Give	XNo		1 ☐ Yes 2 ☒ No		r donto rnoar	1, 6(6.)	Spe	cify:	ite
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Ë	should nd Mer marke imatic	P	James 19a. Informant's Na	William	Hott		105 14-15		Maud			Rotruc		
Maryland	nd 2 s lith an 27 is r r traus		Doris Mo					ng Address <i>(Str</i> ee <i>t</i> B. W. Wash						354
	9 5 5		20a. Method of Disp		inter	20b. Pla		sition (Name of natory or other pla		Date			n - City or T	
OL	ages ant of nt: If i			☐ Cremation 3 ☐ 5 ☐ Other (Specil	Removal from Sta	10			- 1	/14/20	000 1	Elle Co	rden,	1.177
Baltimore,	permit. Pages : Department of I- Important: If its eny injury or of	li	21. Signature of Fu			1.0.	-	Cemetery Name and Addre David A.						WV
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			23a. Part1. Enter the	ne disease, or com	plications that caus	sed the death.								Approximate Interval Between
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	/Medical		resulting in death)	-		as a conseque		Chaj	411	/ure				Syezrs
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			IF FEMALE: 23b. Was decedent	prognant	23c. If yes, outcom	ne of pregnanc	cy					224 1	Date of deliv	2004
Box.	The law requires thet the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	in the past 12	months?		2 Fetal d at time of dea		Ectopic pregnancy Other (specify)	у				Month	Day Year
Ö.	t the by the	hys	9 □ Unknown		9□ Unknown	1								
S,	es the igned be del	by P	Part II. Other signif	icant conditions	contributing to death	but not resulti	ing in the u	nderlying cause giv	ven in Part I.	2	23e. Did tob	acco use co	ontribute to	the cause of death?
ğ	w require been signature	ed	ļ							_ 11	1 □ Ye	s 2 100	3 ☐ Pro	bably 4 Unknown
of Vital Records,	ne iaw n has be ge 2 sh	Completed								2	4a. Was an		D. Were aut	opsy findings available ompletion of cause of
<u>~</u>		E O								_	perform	ned? No	death?	
ita	ilcian: Th certificate rector, pag	Be (25. Was case reference examiner?	red to medical		24			26. Place of					
$\frac{1}{2}$	Physician: r this certificated in all director, in	P,	1 Yes 2		Hospital:		NOutpatien	t 3□DOA Oth	er: 4 ☐ Nursi	ing Home	5 🗌 Reside	nce 6 🗆 C	other (Speci	fy)
n c	ing P	<u></u>	27. Manner of Deatl	5 Pending	28a. Date of Ir (Month, L	njury 2: Day Year)	8b. Time of Injury	28c. Injur Wor			Describe ho	w injury occ	urred	
isi	Attending r death.	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not b		lainer Abban	- 1 1		Yes 2 □ No					
Division	after Direction by	Certification;	4 Homicide	determined	building,	etc. (Specify)	e, rarm, str	eet, factory, office		281. L	cation (Str	, State)	mber or Hun	al Route Number,
	spita nours nerai		29a. Certifier	1 Certifying Ph	ysician: To the be	st of my knowle	edge daéti	occurred at the tir	ma data and o	Naco and d	ue to the ea	the (a)cau	rannar as s	dated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only one)	2 Medical Exar	niner: On the basis and manner	of examination	n and/or inv	vestigation, in my o	pinion, death	occurred at	the time, da	ite and plac	e, and due t	o the cause(s)
	To t To tl	ž	29b. Signature and	title of certifier	1 1.			29c. Licens			29	d. Date sign	ned (Month,	Dey, Year)
ı			1 6	and &	the	ush			272			02	111/	2009
		5	30. Name and addre	ess of person who	completed cause of	_	4.74	Print)	⁷ ST	- 1) a .	,	1.	7
	Sta	te	31. Date filed (Mont	th, Day, Year)	32. Regis	M ろ strar's Signatur	re		, 21		MKL	AND	1 /	W.
3.	Registr		i	FEB 172	009	was f	1. 1	arke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06557 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day LOUISE 7:15 PM V. FEB. 12, 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 9, 1907 Birthplace (State or Foreign
Country) Months Days Hours Min. 1 □ M 2 🗹 F 578-05-2451 102 WASH., DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY TV☐Yes 2☐No ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701- VEIRS DRIVE 20850 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUST OFFICER NAT.SAVINGS & TRUST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARL VEITENTHAL VIRGIE PUMPHREY

5807- OGDEN ROAD,

20b. Place of Disposition (Name of

ARLINGTON NATICEM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2/23/200g

BETHESDA, MD. 20816

20c. Location - City or Town, State

ARLINGTON, VA.

Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hyglene. Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed wit Department of Heath and Mental Hyglen Important: If Item 27 is marked other this any Injury or other traumatic event, The once. **Physician**

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Completed by Funeral

Be

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the Maryland

/Medical

10a. State

MD.

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

20a. Method of Disposition

NANCY MARMARAS- DAUGHTER

Murial 2 Cremation 3 Removal from State

/Medical xaminer or Attending Physician: The law requires that the death certificate be executed

physician and s the burial-trans as nours after death.

neral Director: At 2 nin

Division of Vital Records, P.O. Box 68760,

	21. Signature of Funeral Service Licer	isee	ZZ. IVAITIE	and Address of Facility			
	* W. m. 14	nson			22-WISCON		., NW
	23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused the deat one cause on each line.			1	DC	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a Sudde	n caro	liac death	<u></u>		Onset and Death
	1	Due to (or a a c nseq	í -	-11			20 years
	Sequentially list conditions, it any, leading to immediate	b. Due to (or as a conseq	uence of).	nong			Jews
	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C					
	resulting in death) Last	Due to (or as a conseq	uence of):				
		_d					
in Jointain modification	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	1 death 3 D Ectop	ic pregnancy (specify)		23d. Date of de Month	livery Day Year
7	Part II. Other significant conditions of	•	ulting in the underlyin	g cause given in Part I.	23e. Did tobacc		o the cause of death? robably 4 Unknown
					24a. Was an autopsy performed′	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical examiner?				eath (Check only one)		
	1 Yes 2 No		ER/Outpatient 3		Home 5 ☐ Residence		cify)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
	3 Suicide 6 Could not be determined		ome, farm, street, fact y)	ory, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
	29a. Certifier 1 Certifying Pr (Check only one)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, death occur tion and/or investigat	red at the time, date and pla ion, in my opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner a and place, and due	s stated. to the cause(s)
	29b. Signature and title of certifier			29c. License number		Date signed (Mont	
	Sun S.	malla mi		D005061	2 P.	bruary	13,2009 12085.
	30. Name and address of person who		1 23a) (Type, Print)	rs Drive R	Lockulle	in	0 2000
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Registrar DHMH 17 Rev 1/2001

State

FEB 1 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Mary Ellen Tayman Feb 2009 6:05 PM /Medical 20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis HealthCare The Pines Easton Talbot Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 €□ F Director 81 231-30-7046 Dec. 7, 1927 <u>Pennsylvania</u> Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f sl Examiner must be notified Director 1 ☐ Yes 2 ☑ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25778 Herring Lane United States of Americ Funeral 21629 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian 1 Yes 2 If Yes, Give Year or Dates: 2 □xNo 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify \$ 3 Widowed 4 ☐ Divorced "natural" Caucasian Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 Is marked other trans any Injury or other traumatic event trans once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 HS Grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tayman John William Hobbs Sarah Ariel Sisson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21657 13129 Cherry Lane, Queen Anne, Maryland Susan R. Schorr Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mary 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Crematory 2/21/2009 Dover, Delaware 22. Name and Address of Facility
Moore Funeral Home, P.A. andoph 100% 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) /Medical Examiner Some fitting is to a aller if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ears Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Box 68760 physician Physician/Medical the the attending posterior as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 Other (specify) P.O. 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page perform certificate 1∐ Yes 2□ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ို 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MICHAKL Name and address of person

31. Date filed (Month, Day, Year)

DUTCHMANS

610

on who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

CROWLLY

	1 _ :	For State Registrar		State o	of Maryla		artment o			-	giene Reg. No.	200	9	0655	9
Physician		ecedent's Name	e (First, Middle, L	.ast)						2. Date of De Month			ar	3. Time of Death	_
/Medical	INT	LDA		HEIS						02 -	- 11	- 20	09	3:17 AN	1
Examiner			f not institution, g			,		vn, or Location				County of D			
Funeral	5. Sc	cial Security N	Hospic	Sex	7. Age (In v	rs. last birthday		ear If Unde	r 24 Hrs.	8. Date of Bir	rth.	1 0		ace (State or Foreig	าก
Pirector		8 - 09-57		1 □ M 2 🙀 F	88	Yrs.	Months D	ays Hours	Min.	DEC 4,	1 ⁹ 2(ARY	LAND	,,,
	_	I Residence of													_
r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at completed by Funeral Director		State JAWARE	10b. County SUSSEX			City, Town or L	ocation						10	d. Inside City Limits 1 ☐ Yes 2X No	
Director	100	Street and Nur		-	DA	GSBORO	104 7in Co	40			10- 01	zen of Wha			_
3 2			NEY NECK	ROAD			10f. Zip Co					S A	Countr	y?	
Funeral	11. N	farital Status	THE THE OR	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent If Yes, specify		rigin? (Sp	ecify Yes or No		14. Race - /	America	n Indian.	_
7			ed 2 Married	Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 X No ive		If Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)		Black, V Specify: \[/hite, et	c.	
t, the Medical E.			15. Decedent's l	Education	Jaies.	16a. Dece	edent's Usual O	ccupation	st of worki	na	16b. Kir	nd of Busine	ess/Indu	ıstry	
	Ele	ementary/Seco	ndary (0-12)	College (e kind of work d DO NOT use re RETARY	etired)			MAN	TIP A OTT	IDTN	IC COMPAN	37
î Ç			(First, Middle, Las	st)	<u>′</u>	350	RETAKI	18. Moth	ner's Name	(First, Middle			UKIN	IG COMPAN	<u>Y</u>
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traum	19a.		ame/Relationship		TER		ing Address <i>(St</i> 5 PINEY								
	1	Method of Disp		, Diloci			osition (Name o			DAGSDC		cation - City			_
			Cremation 3 5 ☐ Other (Spec				matory or other COFDEI		FEB :	13, 200					
any injury or other	21.	Signature of Fu	ineral Service Lic	ensee Line)	2	2. Name and A WATSON 211 WAS	ddress of Faci	lity . HOM	E.	-				
	23a	Part 1. Enter t	he disease, or co	mplications that	caused the de							DE I	1	Approximate	_
ian	Imm	ediate Cause (ase or conditio	rt failure. List onl (Final		each line.	TAGI	3 6	RMBI	NTI	4			6	nterval Between Onset and Death	
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ner	. Sea	uentially list cor	nditions.	b											
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Med	IFF	EMALE:													
cian/Med	23b.	Was decedent	propths?		birth 2 F	etal death 3	Ectopic pregi				2	23d. Date of Month		y Day Year	
leted by Physician/Med		1 □ Yes 2/19 □ Unknown	∃No	4 ☐ Preg 9 ☐ Unkr	nant at time o	of death 5	Other (specif	fy)				WIOHIN	L	rear rear	
A P		II. Other signif	icant conditions	contributing to d	eath but not r	resulting in the u	underlying cause	e given in Part	I.	23e. Did t	obacco u	se contribut	e to the	cause of death?	
bd by										10	Yes 2	∫ № 3[] Proba	bly 4 ☐ Unknowi	n
l c										24a. Was		24b. Wer	autops	sy findings available	е е
Be Com											rmed2	prior deat	to com	pletion of cause of ★#No	
Se C		Vas case refer	red to medical					26. Plac	e of Death	1 ☐ Yes (Check only o	2 □No one)	1 🗆	res (INO	_
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tion: To	27. N	nanner of Deatl	h 5 🗌 Pending	28a. Date (Mor	of Injury oth, Day, Year,	28b. Time of Injury	of 28c.	Injury at Work?		28d. Describe		1	,ng/	11421 -12	_
Catie	2	Accident	investigati 6 ☐ Could not	on he			М	1 ☐ Yes 2 ☐							
Certification: To	4	Homicide	determine	d 28e. Place	e of Injury - At ling, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory, off	fice		28f. Location (City or To	Street and wn, State)	d Number o)	r Rural i	Route Number,	
edical	29a.	Certifier (Check only one)	Certifying I	Physician: To the aminer: On the land man	e best of my k pasis of exam nner stated.	knowledge, dea lination and/or i	th occurred at t nvestigation, in	the time, date a my opinion, de	and place, eath occuri	and due to the ed at the time,	cause(s) date and	and manne place, and	r as sta due to t	ited. he cause(s)	
completely lilled in by the Medical Certifical		Signature and	title of certifier		-		29c. Li	cense number			29d. Date	e signed (M	onth, Da	ay, Year)	
		> /	3				De	00586	110		2	1116	9		
	30. N	lame and addr	ess of person wh	o completed cau	se of death (I	tem 23a) (Type						, , ,	/		
	6	HULAN	YWAR	4 COA	STHE	HOSPI	CR i	P.VBI	× 17	33 SA	ws.	Bry	w	21802	
State	31. [Date filed (Mon	th, Day, Year)		Registrar's Sig	gnature	ara d								

State of Maryland / Department of Health and Mental Hygiene 06560 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** February 9:50AM Thomas 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death lanokin Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. 226-30-3240 **Director** 88 12-23-1920 Virginia Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 28a-f show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be modified as Director 1 Yes 2 □ No MD Wicomico Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 266 S. Washington Street Funeral 21863 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ∐Yes 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 .1 and 2 should be filed wi Health and Mental Hygier tem 27 is marked other th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Barney Thomas E11a Crockett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 Health a 10935 Harry Riggin Road, Princess Anne, Maryland Joan M. Jenkins - Daughter permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk. 2-16-2009 Salisbury, Maryland 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complicator's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gouse on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Intracramal 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mitral value Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10.4 cars Examiner death certificate be executed physician and s the burial-trans Afral phillation 104 cars Due to (or as a consequence of): 68760, Physician/Medical ASCVD IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown signed by t t be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate Vital 1 ☐Yes 2 No 1 ☐Yes 2 ☐No or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation s after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Purpose Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DR. USHA NATES AN February 1215 2009 0057359 off 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415.5. BIVISION SALISBURY, MD 21804 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 3 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:30 P Ruby L. Travers 2/22/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Talbot Hospice House Easton Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🔀 F Director 10/16/1914 212-14-4003 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Caroline Federalsburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 21632 4769 Laurel Grove Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specify ģ Specify. 3 ₩ Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene. em 27 is marked other than ther ther traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 3 Crab Picker Shellfish 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Alexander Travers Bertha Horseman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and a Department of Health Important: If Item 27 any injury or other traonce. Nancy Stafford / Daughter 4769 Laurel Grove Rd., Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/25/2009 Dorchester Memorial Park Cambridge, MD 22. Name and Address of Facility 21. Signature of Funeral San Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and led by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 **N**0 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 12 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICO Certification: To After this Date of Injury (Month, Day, Year) 27. Manner of Death 1 ✓ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: A pletely filled in by the fu death. 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 53253 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 136 Lednum Ave. riezek 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01481 State of Maryland / Department of Health and Mental Hygiene 06562 2009 William Patrick Ticer Certificate of Death 1- For State Rea. No Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day February 19, 2009 Physician/ 1959 hrs TICER PATRICK WILLIAM **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Charles Waldorf Eastbound Smallwood Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Hours JULY 1,1978 Months Days MARYLAND Director 1 X M 577-98-6928 Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 10a. State 10h County Yes 2 X No 28a-f show WALDORF s 23a or 28a-f shov e notified at once. CHARLES 10g. Citizen of What Country? with the Maryland Director 10f Zin Code 10e, Street and Numbe U. S. A. 20603 10608 QUILLBACK STREET 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. items, Armed Forces? death v Married 1 X Never Married X Yes WHITE 0 If Yes, Give Year 96-Yes 2 X No 198 Divorced Widowed 16b. Kind of Business/Industry 'natural", Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 b RESTAURANTS event, the Medical other than BARTENDER 21215-0036 12 and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CATHERINE MORSE 27 is marked Be WILMER R. TICER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9500 POOR HOUSE RD., PORT TOBACCO, MD 20677 9 FATHER WILMER R. TICER / 20c. Location - City or Town, State of Health 20b. Place of Disposition (Name of cemetery, FEBRÜARY 20a Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State 1 X Burial 2 WALDORF, MARYLAND 25,2009 TRINITY MEM. GRDNS. portant: jury or oth Other Specify: Donation 5 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. ignature of Funeral Service Licensee 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and ca AMENDED UNPENDED ysician a The law requires that the death certificate be nvsician/Medi 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: ending physuse as the b Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. No 3 Probably 4 V Unknown Yes 2 ð 24b. Were autopsy findings available Completed 24a, Was an Records. prior to completion of cause of autopsy death? performed? has 2 s 1 🗸 Yes Yes 2 certificate page 26.Place of Death (Check only one) 25. Was case referred to medical · Hospital or Attending Physician: 24 hours after death Division of Vital Be Residence 6 🗸 Other: Scene Other₄ Hospital: Nursing Home 5 examiner? DOA Inpatient 2 FR/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject pedestrian struck by motor vehicle After Feb 19, 2009 1953 hrs Certification: Yes 2 V No Natural Pending the Director: 28f. Location (Street and Number or Rural Route Number, City 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Eastbound Smallwood Drive, Waldorf, Md Could not be 3 Suicide determined (Specify) Local Street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

> DHMH 17 Rev 1/2001 OCME 2006

Medical

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

To the

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

00MF

29d. Date signed (Month, Day, Year)

February 20, 2009

and manner stated

30. Name and address of person who completed bouse of death (Item 23a)

JA

Assistant Medical Examiner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last)

Physician
/Medical
Examiner

Director

by Funeral

Completed

Be

ဂ္

Funeral

Director 28a-f show ed other than "natural", or items 23a or 28a-f shov event, the Medical Exa⇔irer must be routified at death v 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than injury or other Pages 1 permit. Pages Department of Important; If it any injury or c

altimore, Maryland 21215-0036

Physician /Medical Examiner

Examine the burial-tran physician Physician/Medical attending p for use as 1 been signed by the should be detached 5 Completed ate has page 2 s certificate director, Be Certification: To this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

or Attending Physician; The law requires that the death certificate be executed

Hospital

WH-6

Division of Vital Records, P.O. Box 68760,

ruary 18, 2009 Harold Newton WINGER c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Min. 1**X** M 2 □ F 171-28-0015 74 11, 1935 Pennsylvania Jan. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c, City, Town or Location 1 □Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21740 113 Southern Oak Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 □Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction manager education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Hussong Albert Winger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Southern Oak Dr., Hagerstown, Maryland 21740 Isabel Winger - wife 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hagerstown Crematory 2/19/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign tuneral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) ELOTIC (AZDIONASCULAZ DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 LINO 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) and title of certifie 29b. Sign 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 11110 Medical Campis Rd. WOOSTCR MD

Registrar DHMH 17 Rev 1/2001

Medical

State

32. Registrar's Signature

09-01392 Mela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06564

ianie vvanigr		1- For State Certificate of Death		Reg.		0000						
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Di February 15,	ay Year	3. Time of Death 0557 hrs						
edical Exam	ner	Melanie Wahlgren 4a. Facility Name (if not institution, give street and number) 4b. City, T	own, or Location of Death		4c. County of Dea	th						
		Calvert Memorial Hospital Prince	Frederick		Calvert							
Funeral		Month:	r 1 Year If Under 24Hrs Days Hours Min		M/DD/YYYY) 9. Birthplace (State or Foreign Country) Wash. DC							
Director		215-21-4720 1 M 2XF 34 Yrs.		05-16-	-19/4 Seamily Wash. DC							
any .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 No						
nd show a	5	MD Calvert Nor	1400	10g. Citizen of What Country?								
Maryla 28a-f	Director	10e. Street and Number		l log.	USA	Juliu y :						
death with the Maryland rr Hems 23a or 28a-f show any must be notified at once.	a D	40. Wes Decedent Ever in LLS 13. Was Decede	0714 int of Hispanic Origin? (S	pecify Yes or No-	No- 14. Race - American Indian, Black,							
1215-0036 Id be filed within 72 hours after death with the filed Wighen Taylor and Taylo	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specific	y Cuban, Mexican, Puerto	Rican, etc.)	White, etc							
after de	by F.	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify: Occupation (Give kind of	work done	Specify: white 16b. Kind of Business/Industry							
72 hours after " "natural", al Examiner	led k	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual during most of wo	rking life. DO NOT use re			, mile of Egonicos and any						
36 hin 72 e. than *	Completed	homemaker			own hor	ne						
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21215-0036 mild be filed within 7 Mental Hygiene. marked other than event, the Medica	o Be	Wallell Hitchart Gazza,	S (Street and Number or			ate, Zip Code)						
MD 2 d 2 shoul lith and N m 27 is m	٦	lames I. Wahleren, spouse P.O. Box	546, North	Beach, M	ID 20714	Taura Stata						
ore, MD 2 es 1 and 2 shoul of Health and IV If item 27 is m		20a. Method of Disposition 20b. Place of Disposition (Na	(:)		20c. Location - City							
altimore, rmit Pages I an partment of Hee uportant: If ite		4 Donation 5 Other Specify: St. Mary's B	ryantown 02	2-21-09	Bryantow	n, MD						
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Inferent 7s areaked other than important; I friem 27 is marked other than inference on other transmatic event, the Medical		21. Signature of Funeral Service Licensee	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736									
Physicia		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode	of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and						
Mudica	1	failure. List only one cause on each line. Death Immediate Cause (Final disease a. Atherosclerotic cardiovascular disease										
amine		or condition resulting in death) Due to (or as a consequence of):										
	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		_5ee								
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O. C. Box 68760, that the death certificate be executed ned by the attending physician and	Modical	X UNPENDED AMENDED 23a,P11,27,perME,			23d. Date of del	ivery						
876(inficate	an se me	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal deat 12 months? Fetal deat	h 3 Ectopic preg	nancy	Month	Day Year						
Box 687, death certifice	or use	past 12 months? 4 Pregnant at time of death 5 Other (St. 1 Yes 2 No 9 V Unknown g Unknown										
). BC the dear	iched id	23b. Was decedent pregnant in the past 12 months? 1	ng cause given in Part I.			e to the cause of death?						
ords, P.O. w requires that the		Diahetes mellitus: hypertension			440	Probably 4 Unknown re autopsy findings available						
rds,	should			24a. Was a autop perfor	sy prio	r to completion of cause of						
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tal Re ction: The certificate	ğ .	u 25. Was case referred to medical	26.Place of Death (Che		Residence 6	Other:						
of Vital Records, ng Physician: The law requir Ofter this certificate has been s	la dir	1 Yes 2 No Inpatient 2 PROUtpatient 3	28c. Injury at Work?		how injury occurred							
on of nding Pl th. r: After	the funeral	O 1X Natural 5 Pending	1 Yes 2 No									
Division tal or Attendiirs after death.	n by th	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fact	ory, office building, etc.	28f. Location (S or Town, S		or Rural Route Number, City						
Division Hospital or Atten 24 hours after death Funeral Director:	filled	4 Homicide determined (Specify) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check pally 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and			my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)						
To the I within 2	сош	and mariner stated.	29c. License number		29d. Date signed	(Month, Day, Year)						
		Land Jacothy 11 MA	O.C.M.E.	=	February 18,	2009						
		30. Name and address of person who completed cause of death (Item 23a)										
		Falliela E. Odditali, M.		J, 141D Z 1201								
	Sta gistr	The of ball lies (Month, Esp. C. O. D.C.C.C.	and the same of th									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1 1 9 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 10 2009 **Physician** Paul Edward Whittington 1920PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 75 578-50-2483 Director Dec 16 1933 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Maryland Calvert Huntingtown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1815 Buckley Road 20639 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. or Items 11. Marital Status Black, White, etc. r than "natural", or Iten the Medical Examiner 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married [°]55–57 1 ☐ Yes 2 🛣 No white Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled win Department of Health and Mental Hygien Important: If Item 27 is marked other that any injury or other traumatic more 9th supervisor/driver salesman Distributor 17. Father's Name (First, Middle, Last) Richard Whittington 18. Mother's Name (First, Middle, Maiden Surname) Be Ida Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Brown Whittington - wife 1815 Buckley Rd. Huntingtown MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 14 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Chesapeake Highlands Memorial Gardens Port Republic MS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee Kausch 4405 Broomes Is. rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OF RIGHT LUNG Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, being a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-trar Due to (or as a consequence of): attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 □ No 9☐Unknown 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BRAIN 1 Yes 2 No 3 Probably 4 Honknown Completed CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ENCEPHALOPATHY performed 1-14/00X1C 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred . After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. he Hospital or Attending P 124 hours after death.

Funeral Director: After to letely filled in by the funeral 1 24 hours a completely filled To the Vithin 2

certificate be executed

Box 68760,

72 hours after death

Maryland 21215-0036

Baltimore,

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

D25435

Feb 10 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukesh Mathur, M.D. Hospital Rd. Prince Frederick MD 20678 32. Registrar's Signature

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 - State Registrar

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Feb. 2009 7:53 a Myra Lee Wolverton /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Frederick Prince 1321 Clay Hammond Road If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2 🛱 F Yrs 8/20/1941 Ohio Director 300-34-5306 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 XYes 2 ☐ No 7 is marked other than "natural", or items 23a or 28a-f sl traumatic event, it e Maxical Examiner must be notified Funeral Director Prince Frederick Calvert 10g. Citizen of What Country? 10e. Street and Number 20678 USA 1321 Clay Hammond Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify. þ White 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Childrens College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than Licensed Practical Nurse Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F 7 is marked otl Pages 1 and 2 should be innent of Health and Mental ant: If item 27 is marked o Grace Marion Davis ည Myron Fuller Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1321 Clay Hammond Rd, Pr. Frederick, MD Catherine Fisher/Daughter permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once. other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 💢 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem, | 2/16/09 | Beltsville, MD 21. Signature of Funeral Service Nicensee 22. Name and Address of Facility Raymond-Wood F.H., P.A. Dunkirk, MD 20754 000 PO Box 430, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 56 wanth Metastach & breast cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 100 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Matural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hin 24 hours a the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)56024 tesmy 11 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prise Frederik 110 Hospital Road Sule 110 Kenneth L. Albit 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Eneur DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amended#31perFCHD Certificate of Death Rea. No. C 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 1:40p February Kenneth G. Wilson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Community Living Inc. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral Days Hours Min. Months 12 M 2□ F Yrs Oct. 8, 1953 Maryland 55 Director 220-76-3552 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, it e Medical Examiner must be notified at 1⊠Yes 2□No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 809 A Motter Avenue Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No 2 If Yes. Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 Elementary/Secondary (0-12) College (1-4or 5+) None None h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Ethel Unknown Martin Wilson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 620-B Research Drive, Frederick, Maryland 21703 Susan Holton/ Caregiver Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc $2/_{18}/09$ Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown 21. Si ature o Funeral Service Licensee Homes Pike, Maryland 21702 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death bladde Immediate Cause (Final disease or condition resulting in death) Concer Physician /Medical Due to (or as a conse ue ce of): Examiner will Sequentially list conditions, Examiner if any, leading to infinedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical s been signed by the attending I should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 Tyes 2 TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes tensio 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has I autopsy performed?

1 Yes 2 No certificate funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 (TPNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 □Yes 2 □No after death.

Director: Aid in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

700 Montclaire Avenue, Frederick, Maryland 21701 Syed Haque MD P. A.

			For State Registrar	State of Ma	arylan		artmen rtificat				ental Hy	giene Reg. No.	2009	06568	3
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Decedent's Name (First, Middle, Last)										3. Time of Death		
And and	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)			4b. City,	Town, or	Location o	of Death	LECT CO	4c.	County of Dea	th	
100	Funeral		5. Social Security Number 6. S			last birthday)	If Under		If Under		8. Date of Bit	rth	9. Bir	thplace (State or Foreign	7
	Director			X M 2 F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Bii (Month, Di NOVEMBER	26,19	927 MAR	YLAND	
	rland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation		-					10d. Inside City Limits	
5-0036	e Mary 3a-f sh lifted	Director	MARYLAND CHARLES		IND	IAN HE								1 XYes 2 □ No	
	with th	1 Dire	10e. Street and Number 10f. Zip Code 100 ELLERBE DRIVE 20640 UNI								Citizen of What Country? NITED STATES				
	death	Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armyed Forces? 1 ☐ Yes 2 □ No If Yes, Give Year or Dates:			S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert				igin? (Spe	Specify Yes or No- to Rican, etc.) 14. Race - A			erican Indian,	
36	rs after	by Fu				1 ☐Yes 2 No Specify:					Specify: B				
5-0036	72 houral	To Be Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working												
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d 21	il Hygie other		17. Father's Name (First, Middle, Last,			ORDINI	TOL I	JQUII			(First, Middle	1		V LIMIT ILLIA	
Maryland	2 should be filed within h and Mental Hygiene. 7 is marked other than traumatic event, Inc. Me		HENRY HORACE WALL	ACE									INSON W		_
Mar	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expriner must be notified at		19a. Informant's Name/Relationship (JANETTE WALLACE—Y		TER	1	-						Town, State, . ARYLAND		
ore,	ss 1 and 2 of Health I item 27 i		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Name	me of other plac	e)	D	ate	20c. Lo	cation - City or	Town, State	_
altimore,	permit. Pages Department of I Important: If its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)		CHARL	ES CE	METE	ERY I				ONT, MA	RYLAND	
Bai	permit. Departr Importa any inju		21. Strayure of Funeral Service Vernses THORNION JOHNSON MOOS83 PADIA C. THORNION JOHNSON MOOS83 PADIA C. THORNION JOHNSON MOOS83 PADIA C. THORNION JOHNSON MOOS83												
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The state of	/Medical Examiner		f	Sever	a consequ	lence or): 1eta,	bol=	c 1	feid	w szy	•				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of): Septicus Shock Due to (or as a consequence of):												
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8760,	ate be hysicia the bur											_			
9 X	eath certific attending p for use as t	/Mec	IF FEMALE:	23c. If yes, outcome	of pregna	incy		(—			2	3d. Date of de	livery	
.O. Box	at the death by the atter tached for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1										Month	Day Year	
ds, P.	es tha	5									23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 □ Probably 4 □ Unknown				
ооэ	law requir as been s 2 should	Completed								24a. Was an autopsy findings a prior to completion of cal			utopsy findings available completion of cause of		
a B	sician: The law certificate has t irector, page 2 sl										perfe 1 □ Yes	ormed? 2 No	death? 1 □ Yes	_	
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	ding Phy h. After thi funeral o	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	28b. Time o Injury	8b. Time of 28c, Inju				28d. Describe how injury occurred					
Division	vttendi death. ctor; A y the fu	icati	2 Accident 3 Suicide 6 Could not be determined 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number,						
Div	al or A s after at Direct	Certification:	determined determined determined building, etc. (Specify)						,	City or Town, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the funeral director, and the funeral director, completely filled in by the funeral director,	Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1,1 (1/	an	29	\ -	e number	7 <i>i</i> 1			e signed (Mon		_
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Song Chon MD, 7C Post Office Rd Lyalcorf, MD 20602								700					
D	831	Song Chan MD, 7C Post Office Rd Waldorf, MD 20602													
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa ساسا	d. A	arke	/			•				

DHMH 17 Rev 1/2001

Wallace, Raymond MR-08434B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 13,3000 Wavne O. Whisnant /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** trion 'eci If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1X M 2□ F 77 240-36-2607 21, 1931 North Carolina Director Nove King To Physicial Othis nort, Libyne O Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 XNo Director Ceci1 North East Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21901 58 Zion Acres Road IISA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1950-72 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: <u>\$</u> White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief Petty Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kathleen Murial McGee ဂ္ Jay Thomas Whisnant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Winifred J. Whisnant/Wife 58 Zion Acres Road, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2-17-2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) T. Foard Funeral Home, P.A. Rising Sun, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Foard Funeral Home, P.A. S. Queen Street, Rising Sun, MD21911 23 art1. Ent. The disease, or convincations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Corse (Final 29000 **Physician** TUKUAM disease or condition resulting in death) /Medical Due to (or as a lonsequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Tyes 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 2 ☐ Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral D

completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) derson who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

ene Crais

FEB 18 2009

Health Care System

YA Mary land /32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15, 2009 Physician February Robert Lee Williams, Sr. 1:00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Ft. Washington Medical Center Ft. Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 24, 5. Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign **Funeral** Days 1940 Pitt County, NC 68 239-60-4959 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 14 Yes 2 No MD Prince George's Oxon Hill Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" any injury or other traumatic average. 20745 920 Forest Drive South USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Black 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7th College (1-4or 5+) Pastor Private 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Williams Mary Newton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 920 Forest Dr. South Oxon Hill, MD Virgie Williams/ Spouse 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Trinity Memorial Gardens 2/21/09 Waldorf, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service, 9908 Sassafras Lane Mitchellville, MD 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date for for as a consequence off Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe fo the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural (Month, Day Year) 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ← Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UG 200 5601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arvind Narasimhan 11711 Livingston Rd. Ft. Washington, MD 20744-5164

State Registrar 31. Date filed (Month, Day, Year) FEB 1 8 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Beatrice 7:50 AM Webster Nina 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Somerset rincess Manokin manor Anne Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/11/1919 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F 89 217-30-8887 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shor 1X Yes 2 □ No Director MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11974 Edgehill Terrace 21853 USA Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 Widowed 4 □ Divorced White Completed of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, I'm Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker none Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sadie Shores Bennie Webster ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a 27607 Oriole Road, Princess Anne, MD 21853 Pat Malone/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date b 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) St. Johns U.M. Cem. 1 02/19/2009 Deal Island, Maryland Signature of Funeral Servi Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, MD 21853 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCUID 54un disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? cate has l autopsy performe certificate 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 40 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 16 15 84 10051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 S.DNISION ST 1415 DRUSHA NATESAN 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year **ELEANOR** RAE WALSTON 9:58 2009 ChRUSEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Peninsula Regional medical Shur WICOMICO 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 577-26-1645 88 Director March 23, 1920 Maryland Usual Residence of Decedent 10b. County 10a, State 10c. City. Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 Wynfall Avenue 21817 U.S.A. death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Deceue... Armed Forces? 1 ☐Yes 2 🗽No 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: ð Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Aide Crisfield MAC Center 11 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked oth Be Clarence Daugherty Lena Dize traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Welch (Daughter) 21817 1 Gandy Lane - Crisfield, MD permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once. other Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 4 Donation 5 Dother (Specify) 2/20/09 Crisfield, MD Signature Duperal Service Licensee

Robert H. Bradshaw 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 5 ð disease or condition resulting in death) /Medical Due to (or * a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed j physician and is the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠ No Month Year Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform Vital 2 🗆 No 1 □ Ýes 2 🖫 funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 👿 No 2 ER/Outpatient 3 DOA Certification: To of this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deatl filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 2 Medical Exa within 2 To the the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 62107 Feb. 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wi/lhite M.D 100 E. Douglas Carroll Street - Salisbury, MD 31. Date filed (Month egistrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 06574 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month February 2009 6:50 20, Maria Elizabeth Woolford 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Homewood at Williamsport Williamsport If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 17, Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months 1 □ M 2 □XF May 90 Yrs 217-09-4590 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 √ Yes 2 □ No Hancock Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21750 129 Limestone Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married

Specify: White

20c. Location - City or Town, State

Berkeley Springs, WV

JACKSTEUN, UNG 21792

Clothing Manufacture

16b. Kind of Business/Industry

18. Mother's Name (First, Middle, Maiden Surname)

Grove Funeral Home, P.A. Hancock, MD 21750-0368

Eva M. Barnhard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

02/23/2009

22. Name and Address of Facility 141 West Main Street

12026 Walnut Point RD Hagerstown, MD 21740

1 ☐ Yes 2 🙀 No

Seamstress

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenway Cemetery

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

If Yes, Give Year or Dates:

College (1-4or 5+)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examinat must be rediffed at any injury or other traumatic event, Ite Modical Examinat must be rediffed at appear. **Physician** /Medical

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

3 X Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Thomas E. Wink

20a. Method of Disposition

19a. Informant's Name/Relationship (Type. Print)

Linda D. Hull/Daughter

21. Signature Funeral Service Licensee

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

15. Decedent's Education (Specify only highest grade completed)

Director

Funeral

Completed by

Be

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Funeral

Director

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat	n. Do not enter the m	ode of dying, such as cardia	ac or respiratory arrest,		Approximate
	Immediate Cause (Final disease or condition	one cause on each line.		MENTIA			Interval Between
	resulting in death)	Due to (or as a consequ	uence of):				
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence)	uanes al):				
cal Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence)	uence of):				
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	I death 3 Ectopia	c pregnancy (specify)		23d. Date of del Month	ivery Day Year
ed by Ph	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the underlying	g cause given in Part I.	23e. Did tøbacci		the cause of death?
Complete					24a. Was an autopsy performed?	death?	topsy findings available completion of cause of 2 \(\sumbox{\text{No}}\)
Be (25. Was case referred to medical examiner?			26. Place of De	eath Check only one		
	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	cify)
Medical Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Daccident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
Sertific	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ıral Route Number,
dical (niner: On the best of my known in the basis of examinations and manner stated.					
Me	29b. Signatury and interference of the contribution of the contrib	Medicar Di	atom	29c. License number	29d. I	Date signed (Molitic	h, Day, Year) 1009

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06575 State of Maryland / Department of Health and Mental Hygiene ? [] [] 9 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day **17 Physician** 2009 10:30 a^M George M. Zeleznik /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Elkridge 7321 Point Patience Way Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min **™** M 2□ F KŠ 11-19-1944 Director 64 212-44-5385 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Elkridge MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21075 7321 Point Patience Way death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after ☐Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No \$ Specify: White 3√2 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boston Properties Property Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Virginia Weade George Zeleznik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7332 Point Patience Way, Elkridge, MD 21075 Health a tem 27 ls David Zeleznik / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Offer (Specify) 2-18-2009 Hanover, MD Ardent Crematory 22. Name and Address of FacilityHarry H. Witzke's Family FH, Inc. 21. Signature of Jun ral Se M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC PANCREATIC CANCER **Physician** disease or condition resulting in death) NEEKS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (dries a consequence of) death certificate be execu burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE for use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate l 1 ☐ Yes 2 🗷 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No death. investigation al or Attend after death. the 1 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi D64395 FEBRUARY 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 DANIEUE DOBERMAN. MO

State

Registrar

32. Registrar's Signature

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death acharias · Month **Physician** Mildred rebrua 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Country Genuis Columbia Howa Howard If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth Funeral Months Days Hours 1 □ M 2 🔀 F 9/3/1931 163-24-7229 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f shov Examiner must be riviffled at 1 ☐ Yes 🏖 No Directo Laurel Md. Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10606 Johns Hopkins Rd. 20723 USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: if item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Experiment page. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **2**€€No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White If Yes, Give Year or Dates: Specify. Completed by 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12yrs Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Brooks Charles Prinkey ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janene Holzberg/daughter 8786 Autumn Hill Drive Ellicott City, Md. 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Ardent Crematory Inc. 2/14/2009 Hanover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign Jure of Funeral Service Licenses 22. Name and Address of Facilit Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of):. **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending PhysIclan: The law requires that the death certificate be executed Exami and the burial-trar Due to (or as a consequence Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 5 Other (specify) 1 ☐ Yes certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No 24a. Was an autopsy 1 X Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1∐Yes 2∭No 2 ER/Outpatient 3 DOA Medical Certification: To this 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 1 🕅 Natural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

State

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

Registrar

and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

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09-01683 Frederick Archer

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	Physicia		egistrar . Decedent's Name (First, Mid	dle,Last)							2.	2	Date of De	eath			Time of Death	1
	el Examir	-	Frederick Jeffre		her						4		Month Februar	y 26, 2	009		1450 hrs	
)	4	a. Facility Name (if not institut	ion, give :	street and nu	ımber)		41	City, Town		cation of	Death		4	c. County of	Death		
			701 North Arlington	Avenue	Apt.415				Baltimor		If the deep	0.41.1==	. Data of	Dieth (NAN	4/DD/VVVV	a Rinthn	lace (State or	Foreign
	Funeral	5	Social Security Number	6. Sex		7. Age (In y	rs. last bir	thday)	If Under 1	Year Days	If Under	Min.			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Count	try)	
	Director		214-38-0789	1 X	M 2 F	68		Yrs.					05-29-	<u>-1940</u>		L	MD	
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	faryland 28a-f show I at once.	ġ.	MD N/A					рател	10f. Zip Co	de	<u> </u>			10g. C	itizen of Wh	at Countr	y?	
	should be filed within 72 hours after death with the Maryland and Menial Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once natic event,	do l	701 N. Arlington	Δτο Δ	nt 415					217				USA				
	th the 23a o		11. Marital Status	1100 1		cedent Ever	in U.S.	13. Was	Decedent	of Hispa	anic Origi	n? (Sp	ecify Yes or	No-			n Indian, Blac	k,
	ath witems	Funeral	1 Never Married 2 X	Married	Armed F			If Ye	es, specify C	uban, I	Mexican,	Puerto I	Rican, etc.)		White			
	ter de		3 Widowed 4	Divorced	If Yes, Give Ye				Yes 2 X				,				an Ameri	can
	be filed within 72 hours after the Hygiene. *ked other than "natural" tent, the Medical Examine.	d b	15. Decedent's Education (S	pecify on	ly highest gra	ade complete	d) 16a	. Decedent	t's Usual Oc ost of workin	cupatio	on (Give k	ind of w	ork done red)	16b	. Kind of Bu	siness/Inc	dustry	
	72 ho	ompleted	Elementary/Secondary (0-1	2)	College	(1-4 or 5+)	T -1			3				Po.	lto Ci	tre Dh	ublic Wo	rks
5-0036	rithin ene. r tha	du	12th				Lidi	borer		11	8 Mother's	Name	(First Midd		en Surname		dDIIC WO	IKS
5-0	Hygi Hygi Jotho the T	ပ	17. Father's Name (First, Mide	dle, Last)									awlings					
2121	uld be filed within Mental Hygiene marked other the event, the Men	Be	Freddie Archer 19a. Informant's Name/Relation	nshin (T	vne. Print)		1	gb. Mailing	Address	1			0		City or Tow	n, State,	Zip Code)	
MD 2	shoul and N 7 is n	-	Sharon Archer-Fer					2220	Orleans	Str	ceet P	alti	more. N	4D 215	231			
		•	20a. Method of Disposition				20b. Place	e of Dispos atory or ot	sition (Name	of cem	netery,		Date	20	c. Location	- City or T	own, State	
Ralfimore	is l		1 X Burial 2 Crema			from State			metery			03-0	7-2009	W	oodlawn	, MD		
	permit. Page Department of Important: injury or oth		4 Donation 5 Other 21. Signature of Funeral Serv	Specify: rice Licen	see				Name and A							Α.		
ä	Depa Inpu		1	()		\supset			N. Gil								A	Interval
1	hysician		23a. Part I. Enter the disease failure. List only one ca	, or domp	dications tha	t caused the	death. Do	not enter t	he mode of	dying,	such as c	ardiac c	or respirator	y arrest,	shock, or he	eart	Approximate Between Or Deat	nset and
	dedica		Immediate Cause (Final dise		Multiple I	njuries								-			Dear	-
	K aminer		or condition resulting in deat	h)	Due to (or a	s a conseque	nce of):											1
ţ		پ	Sequentially list conditions, if any, leading to immediate	b.	Due to (or a	s a conseque	nce of):			_								
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t.	T	Xan	events resulting in death) La		Due to (or a	s a conseque	ence of):											
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` .	EOX 60/00, e death certificate be executed the attending physician and led for use as the burial - transit	Medical	UNPENDED		1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	es, outcome o	f pregnan	ICV							23d. Date	of delivery	/	
1	ificate ing phy	\ <u>\E</u>	IF FEMALE: 23b. Was decedent pregnant	in the		es, outcome o	n pregnan		etal death	3	Ectopi	ic pregn	ancy		Month	0)ay	Year
č	h cert tendir	icia	past 12 months?	Unknowe	-17	egnant at time	e of death	5 0	ther (Spec	fy) _				- }				- 4
Ċ	Kecords, P.O. Box bolow, The law requires that the death certificate be executed icate has been signed by the attending physician and name 2 should be detached for use as the burial - transit	Physician/	1 Yes 2 No 9		3 0.	iknown ig to death bu	t not resu	Iting in the	underlying	cause	given in P	art I.	23e.	Did toba	cco use con	tribute to	the cause of d	eath?
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	S, T puires m sign ld be	l pa												Was an	24b	. Were au	topsy findings	available
	Ord w rec as bec 2 shou	De la												autopsy performe		death?		No
	The la	Completed								0.0	s of Dooth	n (Chec	k only one)	Yes 2	No	1 🗸 Ye	es 2	No
	tal	Be		edical	Hospital: 4 =	Inpatient	2 -	R/Outpatie		OA OA	Other		sing Home	5 Re	esidence 6	✓ Othe	r: Scene	
	Physic Physic rethis	l P	1 Ves 2 No		' '			8b. Time o			ury at Wo		28d. Des	cribe ho	w injury occi	urred		
	nol ding ding l h. Afte	5	1 Natural 5	Pending	Feb	oate of Injury Jonth, Day Year 26, 2009) 1	430 hrs		1	Yes 2	/ No	Subject	assau	lited			
	SIO Atten r death ector:	Cat	2 Accident	Investiga	28e	Place of Injur	y - At hom	ie, farm, sti	reet, factory	office	building,	etc.	28f. Loca	ation (Str	eet and Nur	nber or Ri	ural Route Nur	mber, City
	Division of Vital Records, F.O. Brital or Attending Physician: The law requires that the dours after death. The that Director: After this certificate has been signed by the fitted in he, the fineral director, mage 2 should be detached	Certification:	3 Suicide 6 Homicide	Could no determin	of be	cify) Multi-							701 Nor	own, Sta th Arling	gton Avenu	ue Apt.41	15, Baltimore	, MD
	lospit Lospit A hour uner:	_		ng Physi	ician: To the	best of my k	nowledge	, death occ	curred at the	time, o	date and p	olace, a	nd due to th	e cause(s) and man	ner as sta	ted.	
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certif	Medical	(Check only one) 2 Medica	I Examin	er:On the ba	asis of examin	nation and	l/or investig	gation, in my	opinio	n, death d	occurre	d at the time	, uate ai	iu piace, an	0 000 10 11		-1
		Z	29b. Signature and title of	ertifier	and man		1		290		ise numbe	er					onth, Day, Year	7)
			1/2./11	1	1			2		O.C	.M.E.				February	27, 20		
	^		30. Name and address of p	erson wh	o completed	cause of dea	th (Item 2	(3a)	. 61	4.5	Minn ===	MD	21201	_				
	5		Zabiullah Ali, M.D	. As		edical Exa			enn Stree	е, ва	itimore	, IVID 2	21201					
		Stat	H 4 5 5 6	Year)		2. Registrar's	Signature	has	4									
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			For State Registrar	State of Ma	arylan				lealth ar D <i>eath</i>	nd Me		jiene— leg. No.	000	00070
			1. Decedent's Name (First, Middle, Las	t)							Date of Dear	th	Year	3. Time of Death
	Physici /Medic		FREDERICK			ALPER	N			_ N	1ARCH	1 Day	009	4:00 P ^M
-	Examin		4a. Facility Name (If not institution, give				4b. City,		Location of I	Death		4c. Co	ounty of Death	4EDV
and I			8304 BRADLEY		- 4	4 4 1 44 .2- 3	If Indo	BE r 1 Year	THESDA	Hre lo	Data of Digith		MONTGOM	
	Funeral		5. Social Security Number 6. S 121–28–5570	9X X M 2 □ F 7. Ag	69	last birthday) Yrs.	Months			Min.	Date of Birth (Month Day 01/01/	้ ใช้นก	Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		0.5			L			01/01/	1310		111
	yland yland		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	a-f sl	ctor	MD MONTGOM	ERY		BET	HESD	A						1 □Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zi	p Code			1		n of What Cou	ntry?
	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, tre Medical Exemirer must be institled at	Funeral Director	8304 BRADLEY BL						20817				USA	
	er deg	nue	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Dece f Yes, spe	edent of H ecify Cuba	ispanic Origir ın, Mexican, F	n? (Specit Puerto Ric	y Yes or No- an, etc.)	14	. Race - Ameri Black, White,	etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	NO		1 □Yes	2 🕅 No	Specify:			S	pecity: W	HITE
9	tura stura	ed	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	ual Occup	ation			16b. Kind	of Business/In	dustry
215		ple	(Specify only highest gra	de completed) College (1-4or t	5+)	Give	kind of wo DO NOT L	ork done o use retired	during most o }	f working	Ī			
21	d within giene. er than "	Completed	Elementary, cocontact, (c 12)	5+			PHY	SICI	<u> </u>			M	EDICINE	
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yla	should be filed within and Mental Hygiene. s marked other than umatic event, it e M	은	THEODORE		ALP	ERN				NNA				GOLIS
lar	S S		19a. Informant's Name/Relationship (1	-				Route Numbe ETHESDA		Town, State, Zij 20817	_
e, 1	1 and 2 Health em 27 i		JOANN BOUGHMAN /	MILE	20h F	Place of Dispo			I DEVD	Date			ation - City or To	
יסר	nt of i		1 X Burial 2 ☐ Cremation 3 ☐		0	cemetery, cier	natory`or	other plac					IGS MILI	
Baltimore, Maryland 21215-0036	artme artant ortant injury		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Line)	1//	III				ss of Facility				& BROS.	
Ba	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		MAININE	Pruge		-								, MD 21208
			23a. Part 1. Enter the disease, or com	olications that cause	d the deat	h. Do not ent								Approximate Interval Between
Line .	Physician		shock, or heart failure. List only Immediate Cause (Final			1	1000	40						Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as		uence of):	16112	10						-
	Examiner			h Chronie	- Isid	nea dis	PUSC							& ∞
	₽11/ ≒	iner	Sequentially list conditions, cause. Enter Underlying	Due to or as	a conse	uence of):							1,1	J 4. 7
	and trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			ery di	NO VC	and the same of th						Tears
60,	be ex cian a	<u>E</u>	resulting in death) East	Due to (or as	a conseq	uence or):								
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	eath certific attending p for use as i	/We	IF FEMALE:	23c. If yes, outcome	of pregna	ancy						23	d. Date of deliv	/erv
Box	that the death certil led by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a			☐ Ectopic ☐ Other (s		у				Month	Day Year
P.O.	the c by the	hysi	9 Unknown	9 Unknown										
	uires that the de signed by the a d be detached t	by P	Part II. Other significant conditions of	ontributing to death t	out not res	ulting in the u	nderlying	cause giv	en in Part I.					the cause of death?
Records,	law requires as been sign 2 should be		Hapcoleusico							_	1 □ Y	es 2 🗷	No 3□ Pro	bably 4 🗌 Unknown
ecc	e law re has be re 2 sho	Completed									24a. Was a		24b. Were auto	opsy findings available
Ä	The ate h	ĕ									perfor 1 □ Yes	med?	death? 1 ☐ Yes	ompletion of cause of
/ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?							f Death (Check only or			
≥ \	S S H	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat		ER/Outpatie			4 ⊔ Nurs		5 Resid		☐ Other (Speci	ify)
ū		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay, <i>Year)</i>	28b. Time o Injury		28c. Injur Wor	y at k?		d. Describe h	ow injury o	occurred	
sio	Attending ir death. ector: Afte by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1	ium. At be	ome form et	M M		Yes 2 □ No		Location (C	troot and	Number of Bur	al Route Number,
Division of Vital	l or Attend after death Director:	Certification:	4 ☐ Homicide determined	building, e	tc. (Specia	fy)	eet, iacto	ry, onice		20	City or Tow		Number of Hur	ai noute ivuilibei,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pt	nysician: To the best	of my kno	owledge, deal	h occurre	d at the ti	me, date and	place, an	d due to the	cause(s) a	and manner as	stated.
	e Hos e Fun e Fun ietely	Medical		niner: On the basis and manner s	of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier				25	9c. Licens	e number			29d. Date	signed (Month,	Day, Year)
			> /VW~ M	D				DC.2	283			mar	en 3, 2	P00.
	27		30. Name and address of person who	completed cause of	death (Iter	m 23a) (Type,	Print)	_						

DHMH 17 Rev 1/2001

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Registrar

GAVTAM PAMANI 31. Date filed (Month, Day, Year)

MAR 0 4 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month FEBRUARY 27 2009 **Physician** 7:15P M ROSALIE S. ABRAMS /Medical 4c. County of Death BALTIMORE 4b. City, Town, or Location of Death TOWSON 4a. Facility Name (If not institution, give street and number) Examiner GILCHRIST HOSPICE CARE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06/02/19 16 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F 92 559-38-1785 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Notical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2□No **Funeral Director** BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21208 725 MT. WILSON LANE, #729 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) NofYes 2 No 1 Yes 2 No 1 ☐ Never Married 2 ☐ Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 🌡 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) REGISTERED NURSE NURSING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORA SILBER ISAAC ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4619 WILMSLOW ROAD BALTIMORE, MD 21210 LISSA ABRAMS/DAUGHTER 20b. Place of Disposition (Name of ANSHEED EMUNAH Prother place)
AITZ CHAIM CONG. 20c. Location - City or Town, State 20a Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 03/02/2009 BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee mile 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading minimate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial tran-Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 061 huchry Dill money 4 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📉 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 2501(2 Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 701 N. Charles ST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHALLES

31. Date filed (Month, Day, Year)

MAR 0 4 2009

Physician /Medical Examiner requires that the death certificate be executed burial-tran and Box 68760, the

Physician

/Medical

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10a. State

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Department of Heath and Mental Hygiene. Important: if item 23a or 28a-f show any Injury or other traumatic event, the Thedical Exact increments any Injury or other traumatic event, the Thedical Exact increments.

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Pages

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Maryland 21215-0036

Baltimore,

P.O.

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Division of Vital

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Examiner attending physician Physician/Medical as for use ed by the grached f signed t \$ Completed een) nuer this certificale has funeral director, page 2 s e Hospital or Attending Physician: 24 hours after death. e Funeral Director; After this certifica Be

Certification: To completely filled in by the

29. Was case referred to medical examiner? 1 Tes 27. Manner of Deatl 1X Natural

3 Suicide

29a. Certifier

IF FEMALE

6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

demerrial

29d. Date signed (Month, Day, Year)

anman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

RAHM FAHMI 31. Date filed (Month, Day, Year,

MAR 0 4 2009

32, Registrar's Signature

State Registrar

Medical

within 2 To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marth 1,2009 **Physician** Benthall 1305 Cheryl Ann /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs 8. Date of Birth 1 1 7 2 9 7 1 9 5 4 7. Age (In yrs. last birthday) 54 vrs 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 M 2 XF FIorida **Director** 263-21-0117 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at St.Mary's MD Lexington Park 1 Two 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö USA 22621 Rue Woods Drive 20653 "natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23s any Injury or other traumatic event, tr. Medical Examinant notice. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be A.G.Roberts Daisy May Hinton ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barry Benthall/Husband 22621 Rue Woods Drive Lexington Park, Md20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3 Removal from State 1 ☐ Burial 2 🛛 Cremation Chesapeake Crem.3/04/2009 4 □ Donation 5 □ Other (Specify) Beltsville, Md 21. Signatur Funeral S PHYMOTOPANDESSRINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Urinary tract infection Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner e Hospital or Attending Physician; The law requires that the death certificate be executed 1.24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Acute renal failure Due to (or as a consequence of) Physician/Medical Cellulitis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☒No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à morbid obesity 1 🗌 Yes 2 X No 3 Probably 4 Unknown Be Completed sleep apnea 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy rmed? 2 █ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760 within 24 hor To the Fune completely fi

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

and manner stated.

1500 Forest Glen Road Silver Spring, Md 20910

29c. License number D60826 29d. Date signed (Month, Day, Year)

March 1,2009

shama

29b. Signature and title of certifier

Ksharma Garg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? $\bigcap \bigcap G$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** FEBRUAR 21:29 ()HN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAYVIEW BALTIMORE CITY
If Under 1 Year If Under 24 Hrs. JOHNS HOPKINS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2 □ F 87 January 22,1922 Maryland Director 217-18-0087 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ms 23a or 28a-f short trust be notified at 1 XYes 2 No Director N/A Md. Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 6434 Hartwait Street 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ir than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or item 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White \$ 3½ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Painter Steel 11 years 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brush ပ Stella Zielinska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) : If item 27 or other t Joe Palmerino Stepson 965 Radcliffe Road, Towson Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State March 2, permit. Page Department c Important: If any Injury or once. Baltimore City, Md. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN INJURY 48 hours **Physician** ANSXIC /Medical Due to (or as a consequence of): **Examiner** YPOXIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be exeguted PEA Arrest 50 Hours and burial-tran Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed?

1 Yes 2 200 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide KcrtifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours aft.

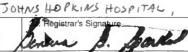
To the Funeral Discompletely filled in within 2.

State

Registrar

CHARLES HAINES 31. Date filed (Month, Day, Year) MAR 0 4 2009

29b. Signature and title of certifier



- MEDICAL DOLTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

FEBRUARY, 26,2009

600 NERTH WOLFE STREET, BALTIMORE, MARY LAND 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a&225tager of the Grand of Health and Mental Hygier []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 11:55 PM March 2009 GEORGE HENRY BOPP /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Point If Under 1 Year VA MARYLAND HEALTH CARE SUSTEM 600r 8. Date of Birth (Month, Day, Year) July 11, 1924 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min Months 1**火** M 2□ F Maryland 84 218-26-8829 Director BOPP; Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Modern Expensive must be notified a 1 □Yes 🗶 🖾 No Director Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21040 603 Charwood Ct. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Affiled Porces? 1 Types 2 Tho If Yes, Give WW 11 Year or Dates. WW 11 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X**XNo Specify: White 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) N/A Self-Employed Handyman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Koppelman John Bopp ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type. Print)
Sexton
Leslie B. Sexon (Daughter) 603 Charwood Ct. Edgewood, Md. 21040 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XIXBurial 2 Cremation 3 Removal from State 200 3-6-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hronic Obstructive Lune Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760,Z Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Eschenic Heart Disease 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Schiziphrenia autopsy perform 1 □Yes 2 No failure to thrive Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.

ieral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral C completely filled 29a. Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number H0054439 March 2, 2009 30. (Name and address of person who completed cause of death (Item 23a) (Type, Print) VA Mary and Health Care System, Perry Point, MD 21902 incent A. Giminaros 9 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend item 29a per dvr 8889 3-4-09 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2009 **Physician** 5:20 PM Gabriel Bertling Herman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes 02/26/1917 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 218-01-0024 92 Yrs. Laurel, MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be rediffed a once. 1 ☐ Yes 2 X No Baltimore Parkville MD Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21234 Apt. 203 U.S.A. 8830 Walther Blwd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heating & Air Elementary/Secondary (0-12) College (1-4or 5+) Carditioning Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herman J. Bertling Mary Levinia Gamer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8830 Walther Blvd. Apt 203 Parkville MD 21234 Margaret Bertling/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Evans Funeral Chapel 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services- Parkville Lelle ran 8800 Harford Rd. Parkville, MD 21234 23a. Par 1. In a fine in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) Usasi 16ten Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. ned by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2, 1 □ Yes 2 □ No 1 ☐Yes 2 ☐No **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 27. Manner of Dealt 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier R043580 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 21. 21234. 0

State Registrar 31. Date filed (Month, Day, Year) MAR 0 4 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 10:56AM Lebruary 27, 2007 Mary Nancy Bosley 40. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Air, Mary Upper Chesapeake Medical
5. Social Security Number 6. Sex 7 Harford Center Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 🕅 F 69 01/11/1940 Marvland 216-36-7385 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1309 Murgatroyd Road 21047 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 [X] No 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2X No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Maryland Redi-Mix 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Frances Griffith John William Messenger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Bosley (husband) 1309 Murgatroyd Road - Fallston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns.03/03/2009 Bel Air, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland casa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4days disease or condition resulting in death) Due to (or as a const uence of): Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 Department of F Important: If ite any Injury or ot once.

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

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Completed

Be

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expression in ust be recalled at

with the Marylan 28a-f show

Baltimore, Maryland 21215-0036

burial-transi sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran completely filled in by the funeral director,

a er death.

within 24 hours arer To the Funeral Direc

Be

Certification: To

Medical

DSCEY MAYLY DOO! 6 Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death? 2 No

	25. Was case referred to medical						26.	Place of Deat	th (Cr	neck only one)
	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	14 Inpatient 2] ER/Outpatient	3 □ [DOA Ot	ther: 4	—— □ Nursing Ho	ome	5 ☐ Residence 6 ☐ Other (Specify)
1	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n	Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Inji Wa 1 [2 □ No	28d.	Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		Place of Injury - At he building, etc. (Special	ome, farm, stree	t, facto	ory, office	9			Location (Street and Number or Rural Route Numb City or Town, State)

29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier

29c. License number D0053568 29d. Date signed (Month, Day, Year)

30. Name and sorress of Jurson who completed cause of death (Item 23a) (Type, Print)

CSCIARA

State Registrar

DSON 32. Registrar's Signati nth, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feoruary 27 2009 ar Carmelo C. Busceni Physician 12:56 A.M /Medical 4a. Facility Name (If not institution, give street and number) Baltimore County Examiner Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month Day, Oct. | 18, | 7. Age (la yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Numbe 213–16–6395 Sex M 2□F **Funeral** Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Forest Hill Maryland Harford County Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21050 103 Shunshine Court Apt. K United States items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1▲ Yes 2 ☐ No Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 'natural", or 1 ☐ Yes 2XXXNo Specify. If Yes, Give à 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that any injury or other traumatic event, Item Once. Bethlehem Steel Forman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Collorfici John Buscemi ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4043 A. BornRoad, Jarrettsville, Maryland 21084 19a. Informant's Name/Relationship (Type. Print) Mr. John Michael Buscami (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland Parkwood Cemetery March 3, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Evans Funeral Chapel & Cremation Services - Bel Air 3 NewportDrive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION INEUMONIA DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and back good access. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the pest 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / ieral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

12+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMAN. 31. Date filed (Month

29b. Signature and title of certifie

N LUARLES ST, SWITE 209 BALTHURE, MO 21204

D64395

29d. Date signed (Month. Dav. Year)

06587

		Registrar			Cer	tificate of	Death		Reg.	No.C 0 0 .	, 0000.
Physician /Medical		. Decedent's Name <i>(First, Middle, L</i> a. Margaret E . Beal l						2. Date Mon Mar	of Death th Ch	1 20°09	3. Time of Death 1 2 : 31 A. M
Examiner		a. Facility Name (If not institution, giv 708 Old Fallston		iber)		4b. City, Town, Fallston	or Location of	Death		4c. County of De Harford	county
Funeral Director	5	Social Security Number 6. S 2 1 6 – 1 8 – 4 9 75	ex □ M 2 X F	7. Age (In yrs. la 88	ast birthday) . Yrs.	If Under 1 Yea Months Days		Min. 8. Date	of Birth oth, Day, Ye.	9. 8 921 Mar	irthplace (State or Foreign Country) Yland
70	ι	sual Residence of Decedent									
/lane	1	Da. State 10b. County			, Town or Lo	cation					10d. Inside City Limits
be Mary 28a-f sh cettor	1	Maryland Harford De. Street and Number	l County	Falls	stan	10f. Zip Code			100	Citizen of What (1 Tyes 2 No
6 after death with the Mar or items 23a or 28a-f st inner must be rediffed Funeral Director	Ľ	708 Old Fallston	Road			21047			Un	ited Sta	
dea dea	1	Marital Status	12. Was Deced	dent Ever in U.S	3. 13. V	Was Decedent of f Yes, specify Cu	Hispanic Origi	in? (Specify Yes	or No-	14. Race - Ar Black, Wh	nerican Indian,
036 urs after al", or ite xorinite by Fu		1 Never Married 2 Married **XX*Widowed 4 Divorced	Armed Ford 1 ∐Yes If Yes, Give Year or Da	e		Yes 2X N		, doise rileari, e	,	Specify: Who	
ted aturn	þ	15. Decedent's Ed	lucation		16a. Deced	dent's Usual Occ	upation		16b	. Kind of Busines	s/Industry
in 72 in 72 in 72	-	(Specify only highest gra	de completed)	400 5 . \	(Give	kind of work don O NOT use retii	e during most a red)	of working	Ba	ltimore	m
21215-003(ed within 72 hours a lygiene. ner than "natural", on, the Medical Exam. Completed by		Elementary/Secondary (0-12)	College (1- N/A	40r 5+)	- Lux r	ede r					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffied at once. To Be Completed by Funeral Director	1	7. Father's Name (First, Middle, Last) Charles Craig					18. Mother's	s Name <i>(First, I</i> Worton	Middle, Maic	den Surname)	
Mary nd 2 shou lith and h 27 is ma r trauma	H	9a. Informant's Name/Relationship (Mrs. Rena Martin		ter)					,	ty or Town, State	
the Hea	2	Oa. Method of Disposition		20b. Pl		sition (Name of natory or other p	· ·	Data	200	Location - City	or Town State
Baltimore, permit. Pages 1 ar Department of Hee mportant: If Item 3 any injury or other page.		1 ☐ Burial 2 【ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State Eval	metery, cren ns Funer	al Chapel	lace) Ma	arch 5,2	2009	Forest	Hill, Maryland
Balt permit Depart Import any in	2	21. Signature of Funeral Service Licer	3m		Ęŵ	Name and Add ans Funer Newport D	al chapel rive, For	l & Cremat rest Hill,	ion So Mary	ervices land 21	s - Bel Air 1050
		23a. Part 1. Enter the dis ase, or com shock, or heart failure. List only	plications that ca	used the death	. Do not ente	er the mode of d	ying, such as c	ardiac or respira	tory arrest,		Approximate Interval Between
Physician		mmediate Cause (Final disease or condition	a. E	LECTR	ON	16 CHAN	ICAL	02810	CIAT	ron	Onset and Death
/Medical Examiner		resulting in death)	Due to (d	or as a consequ	ence of):	SNT 131	CHAGM	c CH	1700		
je j	i	Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events	b. Due to	r as a consequ	ence of):	201 170	ATNOT HE		0		
ox 68760% h certificate be executed ending physician and use as the burial-transit in/Medical Examiner	1	Cause (Disease or injury hat initiated events	c. A71	HEROCC	lecolle	CAND	10 VAS	Culpa	0180	SASE	
68760% rtificate be executing physician and as the burial-tra	ľ	esulting in death) Last	Due to (d	or as a consequ	ence of):						1
ox 6876(n certificate be anding physicis use as the bun n/Medical		•	d								
ortific ing p	1	F FEMALE:									
		23b. Was decedent pregnant	23c. If yes, outo	come of pregnal irth 2 - Fetal	ncy death 3.Γ	Ectopic pregna	ncv			23d. Date of o	
of Vital Records, P.O. Bc Physician: The law requires that the death r this certificate has been signed by the atter ral director, page 2 should be detached for u.		in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of de	eath 5	Other (specify)				Month	Day Year
P.C		9 Unknown	contribution to de	ath hut not room	Iting in the	adarhiaa aayaa	things in Dord I	220	Did toboo	no uno contributo	to the cause of death?
ds, signe	'	art II. Other significant conditions of	ontributing to de	ath but not resu	ning in the ur	idenying cause (given in Part I.	236			Probably 4 Nonknown
al Record The law requir cate has been s page 2 should	-							-	1 🗀 163	1	
Rec e law has t e 2 sl								24a	. Was an autopsy	24b. Were prior t	autopsy findings available o completion of cause of
The I								1 🗆	performed Yes 2	2 death No 1 □ Y	? es 2□No
Vital Fician: The certificate ector, pag	- 2	25. Was case referred to medical examiner?						of Death (Check	only one)		
hysic his collidire		1 Yes 2 No	Hospital: 1 ☐ Ir	npatient 2 🔲 I	ER/Outpatier	ıt 3 □ DOA C	other: 4 🗆 Nurs	sing Home 5	Residence	e 6 □Other (S	oecify)
n o n o ng Pl	2	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Monti	of Injury h, Day, Year)	28b. Time of Injury	28c. In W	jury at ork?	28d. Des	scribe how in	njury occurred	
Vision Attending r death. ector: After by the fune		2 ☐ Accident investigation				M 1	□Yes 2□N	0			
Division of Vital Records, tal or Attending Physician: The law requires the safter death. al Director: After this certificate has been signe led in by the funeral director, page 2 should be coertification: To Be Completed by		3 Suicide 6 Could not b 4 Homicide determined	Zoe. Flace	of Injury - At ho ng, etc. <i>(Specify</i>	me, farm, str	eet, factory, offic	9	28f. Loca City	ation (Street or Town, Si	t a <i>nd Number</i> or tate)	Rural Route Number,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C		29a. Certifier (Check only one) Certifying Pl	nysician: To the niner: On the ba and mann	asis of examinat	vledge, deatl tion and/or in	h occurred at the vestigation, in m	time, date and y opinion, death	d place, and due n occurred at the	to the caus time, date	se(s) and manner and place, and d	as stated. lue to the cause(s)
vithin of the ompl	-	29b. Signature and title of certifier	ΛΛ	11		29c. Lice	nse number		29d.	Date signed (Mo	nth, Day, Year)
F > F 0		•	H K	the	e MJ	0 0	D 26	191		3/3/=	2009
10	1	O Name and address of person who	completed cause	e of death (Item 7, 260	23a) (Type, GA760	Print) WAYDR	1V6, SU	11621/2	2B, R	GLAIR	e, MD 2/014

State Registrar 31. Date filed (Mor

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 0,30 PM Eileen E. Burnette Physician 03 200 OI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Roseda If Under 1 Year 11 Franklin Square Hospi If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye) Age (In yrs. last birthday) 5. Social Security Number 198-30-7037 1941 LANCASTER, **Funeral** Days Hours 1 □ M 2 1 F Months 67 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Madical Exemitar must be notlified at Maryland Baltimore County Parkville 1 ☐ Yes 2XXNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 United States 1748 Forrest Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trainmetrin. Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Supervisor 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arlene Mae Harlinger Frank Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1748 Forrest Ave, Parkville, Maryland 21234 Mr. George Burnette (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Bel Air Memorial Gardens March 5,2009 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services -3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Bel Air train () for 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cell Denc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar P.O. Box 68760, Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatuj nd title of certifie

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month)

Burrett

9000 Franklin Square Dr., Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D63054

larch 1.

21237

2009

2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Bonsuk Rose February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 504 Matthews Avenue If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 220 14 2108 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location or 28a-f show injury or other traumatic event, the Medical Examination must be multified at Director Baltimore Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 504 Matthews Avenue 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. <u>6</u> 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ital Ital Elementary/Secondary (0-12) College (1-4or 5+) 8th Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Peter Doropiewich Julia Dworkowski ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 504 Matthews Avenue Joseph Bonsuk / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State State Veterans Cem. 03/03/2009 | Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PMEN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

9 Unknown

1 Live birth 2 Fetal death 4 Pregnant at time of death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4c. County of Death Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Maryland 07/25/1925 10d. Inside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Washington Aluminum Baltimore, Maryland 21225 20c. Location - City or Town, State 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Griffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2714 2009

Reg. No.

26,

2009

3. Time of Death

4:50 P. M

Box 68760, o σ. Division of Vital Records,

Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

10

MAR 04

5 Pending

investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

3 Suicide

2 Accident

4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Il Director: /

State Registra DHMH 17 Rev 1/2001 3 Ectopic pregnancy

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-01678 Nathaniel Braxton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

06590 2009

		For State	Certific	ate of Death		Reg. No		3. Time of Death	
Physician	1/ 1.	Decedent's Name (First, Middle,Last)			2. Date of Month Febru	of Death Day Jary 26, 2	Year 009	1525 hrs	
Examin		Nathaniel a. Facility Name (If not Institution, give street and	Henry	Braxton 4b. City, Town, or Locati		4	c. County of De	eath	
	4	Bon Secours Hospital	a manusery	Baltimore			• • • • •	e e	
	5	. Social Security Number 6. Sex	7. Age (In. yrs. last bir	Hiday)		e of Birth (MN	I/DD/YYYY) 9. Fo	Birthplace (State or reign	
Funeral Director			F 52	Yrs. Months Days H	ours Min.	- 08	56	Country) MD	
Director		Jsual Residence of Decedent	32					10d. Inside City	Limits
any		10a. State 10b. County	10c. City, Town	n or Location				1X Yes 2	
. ≱		MD NA	Ba	ltimore	The state of				
Maryland 28a-f show d at once	Director	10e. Street and Number		10f. Zip Code		. 10g. C	itizen of What (Country?	
ith the Ma 23a or 28 notified	Ë	2228 Poplar Grove	Street	212.	16		U.S.A	merican Indian, Black	
with the same is 23a		11. Marital Status :: 12. Was	Decedent Ever in U.S. ed Forces?	13. Was Decedent of Hispania If Yes, specify Cuban, Me	c Origin? (Specify Ye xican, Puerto Rican, e	etc.)	White, et		
eath ritem	an	1 X Never Married 2 Married 1	res 2x No .	1 Yes 2 Y No sp			Specify: E	Black	
after d	by F	3 Wildowed 4 Divorced If Yes, Giver or Dates:		a. Decedent's Usual Occupation (ne 16t	. Kind of Busin		
should be filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once natic event, the Medical Examiner.		15. Decedent's Education (Specify only highes		during most of working life. DO	NOT use retired)			*	
hin 72 h e. than "n edical E	ompleted	Elementary Cooking and Co	ege (1-4 or 5+) na	Mechanic				Alley	
filed within 77 Hygiene. d other than , the Medical	E	12th grade I	ila j	18.M	tother's Name (First,				
Hygien d other	O	William Henry Bra:	xton	G	ladys Ma	e Fau	lker	with the second	
hould be fill ad Mental F is marked tic event,	o Be	19a. Informant's Name/Relationship (Type, Prin		19b. Mailing Address (Street an	d Number or Rural Ro	oute Number	, City or Town;	State, Zip Code)	6
should be filed within and Mental Hygiene. 7 is marked other that artic event, the Mental Hygiene.	F	Rosalind Braxton	McGill	2228 Poplar e of Disposition (Name of cemete	Grove St	reet	Balt	imore, M	ă.
nd 2 salth sm 2 raun		20a. Method of Disposition	200. 1 180	ce of Disposition (Name of cemete matory or other place)	ery, Date	20	oc. Location - C	ity or Town, Stele	
		1 X Burial 2 Cremation 3 Remo	oval from State	: Carmel	3/5/0	9 E	Baltim	ore, Md	
permit. Pages Department of Important: If	-1.	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	0	22 Name and Address of	Facility	To Jan 10			
permit. Departit Importi		Minimala	KNIMK	March F/H 4300 Wabas	h ATTO B	altir	nore,	Md 2121	
	·	23a. Partyl. Enter the disease; or complications	that caused the death. Do	o not enter the mode of dying, suc	ch as cardiac or respi	ratory.arrest,	shock, or hear	Between On	nset a
hysician edical		faiture. List only one cause on each line.						Deat	th
		Immediate Cause (Final disease a. ACI		c. cardiovascula	ar disease				
.aminer		Immediate Cause (Final disease a Att or condition resulting in death) Due to (or as a consequence of):	c cardiovascula	ar disease		1,43		
.aminer		or condition resulting in death) Due to (or as a consequence of):	.c cardiovascula	ir disease				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Vear Physician Marie 8:10 02 200 Z6-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1668 W. North Ave Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 💢 F 220-20-7226 Director 08-02-1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show Examiner must be notified at Director 1 X Yes 2 □ No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò items 23a 1668 W, North Ave 21217 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Tyes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'n, If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: African American þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Factory Seamstress 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Wesley Johnson JoAnna E. Inman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trau Wesley Robert Jenifer/Nephew 250 New Castle Drive Shillington, PA 19607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park National 03-06-2009 Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home P.A. ura of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to or as a consequence of): disease or condition resulting in death) infarction /Medical **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown nemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier everdson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichardson, MD 4340 Park Heights Are 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 0 4 2009 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryla		epartment of F Certificate of I		ntal Hygie	ene 1. No. 2009	06592
	Physicia		1. Decedent's Name (First, Middle, La	77 -			2	Date of Death Month Fels	Day Year 200	
Q	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give Howard Courty (5. Social Security Number 6. S	e street and number) GENERAL Hus	Y (TAL rs. last birtho	(ay) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	. Date of Birth (Month, Day,	4c. County of Dea	ath
	tand ow		Usual Residence of Decedent 10a. State 10b. County		City, Town o	r Location				10d. Inside City Limits
	ne Mary 18a-f sh	ector	Maryland Howard	Co	lumbia					1 ☐ Yes 2 ☐ No
	h with th	al Dir	10e. Street and Number 6336 Cedar Lane	, Apt. 160		10f. Zip Code 21044		100	g. Citizen of What C USA	ountry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1	U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 □XNo	ispanic Origin? (Speci in, Mexican, Puerto Rid Specify:	fy Yes or No- can, etc.)	14. Race - Am Black, Whi Specify:	
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Maryland 21215-0036	ed withii lygiene. ner than it, the M	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		all Busines	s Admin.	C		pecialist
land	ild be fill fental H rked ott	To Be	17. Father's Name (First, Middle, Last, Ernest Linw				18. Mother's Name (# Henrietta			layne
Aary	2 shou h and M is mai raumat		19a. Informant's Name/Relationship (Margaret E. Bell	**		lailing Address (Street			•	•
re, l	s 1 and of Health Item 27 other 1		20a. Method of Disposition	201		36 Cedar La isposition (Name of crematory or other place)			Lumbia, M oc. Location - City o	
Baltimore,	it. Page rtment c rtant: If njury or		1 ☑ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y) Lo		Park Cemete	ry 3/3/09		<u>`</u>	Maryland
Bal	Depa Impo any I		21. Signature of Funeral Service Licer	1500		22. Name and Addre	ns Ave., B		Funeral e. MD 212	
77	Physician /Medical		23a. Part 1. Emer the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line. A light	nt A	enter the mode of dyin	ig, such as cardiac or i			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that linitiated events	b. Corenar Due to (or as a cons			ease			
58760,	icate be executed physician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hypest. Due to (dr as a cons	equence of):					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
	quires that in signed b uld be deta	þ	Part II. Other significant conditions of	contributing to death but not	resulting in th	ne underlying cause giv	en in Part I.		cco use contribute	to the cause of death? Probably 4 🔀 Unknown
Division of Vital Records,	The law recate has bee page 2 shot	Completed	4-,0-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of s 2 \sumbed No
Vita	slcian: s certific lirector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2	T EB/Outs	atient 3 DOA Oth	26. Place of Death (ce 6 □ Other (Sp	
ion of	ending Phy ath. ir: After thi	Certification: To	27. Manner of Death **Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year	28b. Tim	ne of 28c. Injur		d. Describe how		ecny
Divis	al or Atters after de	Sertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		t home, farm ec <i>ify)</i>	, street, factory, office	28	f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying PI 2 Medical Example (Check only one)	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, o hination and/o	death occurred at the til or investigation, in my d	me, date and place, an ppinion, death occurred	d due to the cau at the time, dat	use(s) and manner a e and place, and du	as stated. e to the cause(s)
		M	29b. Signature and title of Artified	_ MO		29c. Licens	e number		Eb 27	th, Day, Year)
	541		30. Name and address of person who Michael Perlin	completed cause of death (I		pe, Print)	o (umbic		1044	
	Sta Registr	te	31. Date filed (Month, Day, Year) MAR 0 4 20	09 Sekus	gnature	2.00		- V C	(1	
DI	MH 17 Rev 1/2		4 2 20	- remain	P. 6					

DHMH 17 Rev 1/2001

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amend #31 Per DVR C889 3/04/09 JH
State of Maryland / Department of Health and Mental Hygiene
amend #5 Per INF G891 5/18/09 JH

Beg. No 2 0 9 Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:30 A^M 1, 2009 March Bradley Bradford /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Warm Heart Assisted Living Germantown Montgomery 8. Date of Birth (Month, Day, Year, July 21, 1 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Country) 1 □ M 2 T F Yrs. 96 Arkansas 557-36-1004 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director Maryland | Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 20874 18441 Crownsgate Circle Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Completed by White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be Department of Health and Memortant: If item 27 1- any Injury or any Inju Minnie Smith James Emmett Bradley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11458 Fruitwood Way, Germantown, MD 20876 Ann Bradford 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Culpepper Cemetery 3/6/09 Clinton, AR 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Roller-McNutt Funeral Home 1902 Hwy. 65 South, Clinton, 21. Signature of Funeral Service Licensee AR 72031 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ementia 4 ear Physician 4/2 heimers /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed A pia burial-transit Due to (or as a consequence of) Box 68760. aftending physician Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day for 5 Other (specify) 4☐Pregnant at time of death Division or Vital Records, P.O. been signed by the sahould be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No N autopsy page performed certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 6 roup Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient ဥ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 9b. Signature and title of pertifier nd address of person who completed cause of death (Item 23a) (Type, Print) 911 RussellAve. Gaithersburg ,MD 20879 John R. Melnick 31. Date filed (Month, Day, Year)

State

Registrar

MAR 0 4 2009

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MÄRCH ďΥ 2009 IDA BENDER 7:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LEVINDALE HEBREW HOME BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth 11-12-1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 YF 104-14-5870 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ¥ Yes 2 □ No Directo MD NA Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2500 W. Belvedere Avenue #310 21215 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homema ker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Cohen Martha Katz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 W. Belvedere Avenue #310 19a. Informant's Name/Relationship (Type. Print) Julius Bender / Husband 20b. Place of disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-01-2009 Pinelawn New York New Montifiore Cem 21. Signature of Funeral Service SOL NAME OF THE PROSE ROS. 8900 Reisterstown Road Baltimore, Maryland 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DEMENITIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit one property. resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 █ No 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20063327 POLITHWIT. WOLD ETHINOT MARCH 01, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 WIBELVEDERE AVE, BALTIMORE, MD 21215 GIZAW WOLDELTIWOT, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State

Registrar

MAR 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	arylan		artment o r <i>tificate</i>			lental H	giene Reg. No		9 0	6595
			1. Decedent's Name (First, Middle, Last	1)						2. Date of D	eath		3. Tir	ne of Death
	Physici /Medio		Anne M. Burns						ŀ	Month EBRNAR	∠ 2	7 200		5 P M
A. C. C.	Examir		4a. Facility Name (If not institution, give	street and number)				n, or Locatio	n of Death		7	County of D	eath	
- North				SPITAL				MORE			`			
	Funeral		5. Social Security Number 6. Se	x 7. Age □ M 2 🔀 F		ast birthday)	If Under 1 Y Months D	ear If Und ays Hour	er 24 Hrs. s Min.	8. Date of B (Month, D	irth Day, Year)	9. I	Country)	ate or Foreign
	Director		212-05-1197		90	Yrs.				06/28	/1918	B Ma	aryland	<u> </u>
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Insi	de City Limits
	Maryl f sho	ō	Maryland N/A		Dol	timore								Yes 2∐No
	the 283	rec	10e. Street and Number		Dal	CINOLE	10f. Zip Co	de			10a, Cit	izen of What	Country?	
	death with the Maryland ms 23a or 28a-f show	Funeral Director	707 Maiden Choice	Lane Apt.	. 7G1	5	2122	8			Uni	ted St	ates	
	death ms 2	Jer	11. Marital Status	12. Was Decedent B			Was Decedent f Yes, specify		Origin? (Spe	cify Yes or N		14. Race - A		n,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exaction of the traumatic event, the Modical Exaction of the Indianal Angles.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ∐Yes 2 XIN If Yes, Give Year or Dates:	lo		fYes, specify I⊡Yes 2 ∑			Rican, etc.)		Black, W	white, etc. White	
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pu	be fill d oth even	Be	17. Father's Name (First, Middle, Last)							(First, Middle		Surname)		
yla	ould Mer narke	မ	John Carrigan			· · · · · · · · · · · · · · · · · · ·				e Downs				
Jar	2 sh h and ris m		19a. Informant's Name/Relationship (T)				ig Address (St				-			
6,	l and Health		Michael M. Burns	- Son	Took Di		Raynor			<u>-</u>				
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	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
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	execu n and al-tra	Xai	that initiated events resulting in death) Last	c Due to (or as a	a consequ	ence of):								
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Вох	eath certific attending pl	N/I	200. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			1 <i>c-</i> 4:					23d. Date of	delivery	
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Ö	after after Dire d in b	Certification:	4 Homicide determined	building, etc	. (Specify)	, , , , , , , , , , , , , , , , , , , ,			City or To	wn, State,)	ridiai riodie	varriber,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fun	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examinat	vledge, death ion and/or in	occurred at to restigation, in	ne time, date my opinion, d	and place, a leath occurre	and due to the	e cause(s) , date and	and manner place, and d	as stated. lue to the cau	se(s)
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	k /		30. Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type, I	Print)	1 4				1		21229
-	0 0		DAVID A. VITE			900	CATON	AVE	MA	ILBOX	062	BALT	MORE	MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06596 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Month February ohnnie ole 35 AM /Medical Facility Name (If not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Health and atonsville Baltimore Kehab ummit If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min. Year) 242-60-049 Director August Carolina Usual Residence of Decedent with the Marylan r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Modical Examiner must be i 21229 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Wo <u>ک</u> Yes. Give Specify: 3 ₩idowed 4 Divorced Black Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked o 01 Ve ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) We Norday onnnie Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 Surial 2 Cremation 3 Removal from State 6/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell 21. Sign vor + of Funeral Service Licensee MO 20794 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death +CQUIREN LMMUNE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NOREXIA Sequentially list conditions, if any, leading to infilinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) burial-transit FALURE RENA and The law requires that the death certificate be execu Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death Month Year signed by the a d be detached f 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð WITH mfL/ANCE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate Division of Vital 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu death. 2 Accident 1 ☐Yes 2 ☐No 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) ALL ENOWS DO057948 MARCH 4 2009

State Registrar Date filed (Month, Day, Year)

22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MITE 3H

BATIMONE

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10515

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 mend Items 25,27,28a-f per mencals of 3/04/09dhb

Reg. No.

			1 - State AMENG IT		- Cei	micate of	3/04/09dh	R	eg. No.	
I	Physici	an	1. Decedent's Name (First, Middle, La BYROW BECK		MPRA i			2. Date of Deat Month	Day Year	
P. Sales	/Medic	al	4a. Facility Name (If not institution, gir	ve street and number)			r Location of Death	ftB_	4c. County of De	
ng di			HOWARD COUNTY			Con Ly	If Under 24 Hrs.	8. Date of Birth	Howe	
	Funeral Director			Sex 7. Age (Ir	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) S/ZO IV	irthplace (State or Foreign Country) EW YORK
	yland how		10a. State 10b. County	1	c. City, Town or Lo	/				10d. Inside City Limits
	he Mai	ecto	10e, Street and Number			10f. Zip Code	A	11	0g. Citizen of What 0	1. ■Yes 2 □ No
	23a or	al Dir	10e. Street and Number 5659 SHEE R	OCK COV	Rt	1	045		US	-
	er deat	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
036	within 72 hours after death with the Maryland ene. than "ratural", or items 23a or 28a-f show he Modical Examinat neast be modified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: 3	LACK
21215-0036	"natur	Completed	15. Decedent's E (Specify only highest gr	Education rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Busines	
212	d withir giene. er than	omb	Elementary/Secondary (0-12)	College (1-4or 5+)		TEACH	r'		EDUCE	4 TOON
	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Las PNUS +ON CHI				18. Mother's Name		Maiden Surname) ROET (~
Maryland	should and Mer s marke umatic	우	19a. Informant's Name/Relationship	/	19b. Mailir	ng Address (Street			r, City or Town, State	
	and 2 Health a m 27 ls		DONALD H. SER	CON9-SON	565	9 SHEEN	OCK Ct,	Column	01/4, 11/1/D 20c. Location - City of	21045
nor	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar satment of Health and Mental Hygiene. ioritant if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner mast be notified at 8a.		20a. Method of Disposition 1 ▲ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Content of the Conte	_ Removal from State	cemetery, crei	natory or other plac	ce)		BROOKLY	- 1
Baltimore,	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice		2 22	2. Name and Addre	ess of Facility 400	Well A	were ac	10000 Q
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	Physician		Immediate Cause (Final disease or condition resulting in death)	DEBIL	ITV			1 69	MEDICAL EL	Onset and Death
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month March 02, 2009 Year 4:16 P. M Gloría Ann Culbertson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford County Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year)
April 06,1954
Baltinore, MiD. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 1 F 54 Months Days Hours 217-64-4067 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Harford County Aberdeen 1 ☐ Yes 2 No Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21001 United States 271 Golf Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Title Company Settlement Officer n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Casimer Kordek Edith Marie Bruno 2 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aberdeen, Maryland 271 Golf Drive 21001 Mr. Kenneth Edgar Culbertson, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) March 04, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel 2009 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 191 23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart lailure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Discourse of the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, such as cardiac or respiratory arrest, shock or repair to the mode of dying, shock or repai Approximate Interval Between Onset and Death JUC Due to (res a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? δ Cerebral 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

P.O. Box 68760, (& The law requires that the death certificate be executed signed by the attending p Division of Vital Records, certificate has been s rector, page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, I

Gloria

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Physician

/Medical

Examiner

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Intent and I flem 27 is marked other than "natural", or ite my or other traumatic event, the Medical Experimenty or other traumatic event, the Medical Experimenty

permit. Pages 1 and 2 shr Department of Health and Important: If Item 27 is m. any Injury or other traum. once.

Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

with the Maryland

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Be

State Registrar 29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chesapeake Dr. Bel Aic. 500 Upper 31. Date filed (Month, Day, Year) **NAR 0 4 2009**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () 06599 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 15:15 pm Thomas Oliver Canning esturry 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1-105bital BALTIMORE Agnes If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) 10/29/1924 Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □ F 215-56-5283 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Baltimore 1 ☐ Yes 2 ☐ No Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g_Citizen of What Country? UNITED States 1709 Chesterton Road 21244 America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1. Never Married 2 ☐ Married 1 □Yes 2√√No Specify. Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unemployed unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Hugh Canning Mable Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joyce Cates/ socialworker 2822 Hollins Ferry Road Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State March 6, 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 2009 21. Signature of uneral Service Licenses 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final - Anoxil en apphalo Ol ela disease or condition resulting in death) Due to (or as a consequence of): - Hypercus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): A Spirati Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expraisor must be mutified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. E

THOMAS

ANNING

Division of Vital Records.

Examiner Physician/Medical Completed by Be Certification: To

9 LI OTIKITOWIT				
Part II. Other significant conditions co	ntributing to death but not resulting in the underlyin	ng cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
- dysphogia	and asporation		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical	· -	26. Place of Death	(Check only one)	
examiner? 1 Yes 2 40	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Specify)
27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	etory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
	rsician: To the best of my knowledge, death occur iner: On the basis of examination and/or investiga and manner stated.			
		00 11	201.0	

State

29b. Signature and title of certifie

FEHAI, BENRAOUANE,

,28,2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENDLADUANE, 31. Date filed (Month, Day, Year)

Registrar

Medical

09-01708 Helen Chaney Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	1- For	r State trar		Certificat	te of D	eath			Reg. N	<u>.</u> 200	9 0000
Physician/ ledical Examine	1. De	ecedent's Name (First, Middle	c,Last) Chaney						of Death th Day uary 27, 2	/ Year 2009	3. Time of Death 1939 hrs
		acility Name (if not institution Baltimore Washington		=		City, Town, or Glen Burnie		Death	-2	4c. County of Deat Anne Arunde	
Funeral Director	26	1-84-4479	6. Sex 7. Age (I	In yrs. last birtho		If Under 1 Year Months Days		Min.	te of Birth (M	Co	rthplace (State or Foreign buntry) GA
Maryland 28a-f show any d at once. rector	10a.	Residence of Decedent State 10b. County ryland Anne	a Arundel	c. City, Town or	Location	Pas	sadena	a			10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.		Street and Number 06 10th Stree				0f. Zip Code	2112			Citizen of What Cou	
	3	Marital Status Never Married 2 X Ma Widowed 4 Dive	12. Was Decedent Ev Armed Forces? 1 Yes 2 X		If Yes,	Decedent of His specify Cuban	, Mexican, F			White, etc.	rican Indian, Black, White
5-0036 led within 72 hours after death with the Maryland bygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	15.	ementary/Secondary (0-12)	Loc Dates: cify only highest grade completed College (1-4 or 5+)	dı dı	aring most	Usual Occupat of working life.	DO NOT u		ie 16b	. Kind of Business	/industry
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica		12 Father's Name (First, Middle,	•		Off	ice Man	18.Mother's	Name (First, M			
Should be fill and Mental H 7 is marked matic event, t	19a.	Foster Car Informant's Name/Relationsh	nip (Type, Print)		•	,		er or Rural Ro		City or Town, Stat	ter e, Zip Code)
re, M s 1 and 2 of Health If item 2	20a.	win Chaney Method of Disposition Burial 2 Cremation	(spouse) 3 Removal from State	20b. Place of cremator	Disposition by or other		netery,	Date March	06	c. Location - City o	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr	-	Donation 5 Other Sp Ingnature of Funeral Service		Maryla	_			2009 Sta Road,			Home, P.A.
Physician /Medical	4	failure. List only one cause	onplications that caused the on each line. a. Hypertensive Athe					rdiac or respira	atory arrest, s	shock, or heart	Approximate Interval Between Onset and Death
xaminer	or co	ediate Cause (Final disease ondition resulting in death)	Due to (or as a consequence)		Cardib	agodiai Die	case				
ted Insit Examiner	if an caus	uentially list conditions, y, leading to immediate se. Enter Underlying Cause ease or injury that initiated	Due to (or as a consequ								
760, icate be executed by physician and the burial - transit	ever	nts resulting in death) Last	d.				- <u> </u>				
x 68760, It certificate be executed tending physician and use as the burial - transi cian/Medical E.		EMALE: Was decedent pregnant in thosast 12 months?	Live birti	2	Fetal	death 3	Ectopic	pregnancy		23d. Date of delive	rry Day Year
the death certify the death certify by the attending the for use as Physician	1 [nown 9 Unknown ons contributing to death b			(Specify)	riven in Pari	+1 23	Se. Did tobac	co use contribute t	o the cause of death?
S, P.O. puires that the signed by tild be detach	3	n. Other significant conditi	ons contributing to death b		THE CITE			1		No 3 Pro	obably 4 V Unknown
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as nedical Certification: To Be Completed by Physician						_		1 .	autopsy performed Yes 2	prior to	completion of cause of
Vital ysician: his certi director	ּ בֿ	Vas case referred to medical examiner?	11	2 ✔ ER/Out	tpatient		Othor	Check only one Nursing Home		sidence 6 Oth	er:
ion of Virending Physicath. Ior: After this the funeral direction: To	27 1	1 Yes 2 No Manner of Death Natural 5 Pend	28a. Date of Injury (Month, Day, Year	28b. T	ime of Inju	ıry 28c. İnju	ry at Work? Yes 2 l	28d. De		injury occurred	
Division o Bostial or Attending 24 hours after death. Funeral Director: Afterly filled in by the fune	3 4	Suicide 6 Coul	d not be mined (Specify)	ry - At home, far	m, street,	factory, office t	ouilding, etc		cation (Stree Town, State		Rural Route Number, City
To the Hosy within 24 hr To the Fun completely i			nysician: To the best of my k miner:On the basis of examin and manner stated.								
	29b.	Signature and title of certifie				29c. Licens O.C.				ebruary 28, 20	
'o v		Name and address of person Russell Alexander MD		l Examiner	111 F	enn Street	, Baltimoi	re, MD 212	01		
Stat	e 31. I	Date filed (Monager, Dar	32. egistrar's	Signature	Z	All					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	iryiand		rtment of r tificate of	Health and N <i>Death</i>		Reg. No	711114	06601	
	Physicia	n	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Da		3. Time of Death		
	/Medic	al -	Mildred J. Croc		e street and number)			4b. City, Town, c	r Location of Death	02-28-20		c. County of Dea	4:45p M	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo 5315 Norwood Ave Baltimore											
	Funeral Director		5. Social Security Number 215-30-0578		ex □M 2X F 7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di	th ay, Ye <i>ar</i> 934	9. Bi	rthplace (State or Foreign ountry) MD	
	rland row	Director	Usual Residence of Deced 10a. State 10b. (County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	e Mar		MD N/A	A		Balti	more						1 X Yes 2 No	
	with th		10e. Street and Number					10f. Zip Code 21207			117.0	itizen of What C SA	ountry?	
15-0036	be filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, I'm Medical Evaring must be rediffed at	Funer	5315 Norwood Ave 11. Marital Status 1 □ Never Married 2		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give				Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Am Black, Whi	te, etc.	
	ural",	pd by	3 Widowed 4 Di		Year or Dates:	-		lent's Usual Occu			16h	Kind of Business	ican American	
	in 72 l	plete	(Specify only		de completed) College (1-4or 5-	1	(Give	kind of work done OO NOT use retire	during most of work	ring	l lob. I	Ithia of Business	s/moustry	
7 7	d within /giene. er than "	To Be Completed	Elementary/Secondary (0-12)	College (1-461 5		Chef						otor Lodge	
and			17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Midd Plumia Knox					le, Maiden Surname)		
\geq	s 1 and 2 should I Health and Men item 27 is marke other traumatic		Solace Spence:		Type. Print)		19b. Mailir	ig Address (Street			oute Number, City or Town, State, Zip Code)			
more, ma	and 2 sealth an n 27 is		Linda Crockett				2559 S	eamon Ave 1	Baltimore, N	1D 21225				
	0 - 5		20a. Method of Disposition 1 ☐ Burial 2 X Cren	1		20b. Pla	ce of Dispo netery, crer	sition (Name of natory or other pla		Date		Location - City o		
Ē	permit. Pages Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ C	ther (Specify	y)	Metro	Crema	-	03-03- ess of Facility Wy]			timore, MI)	
Baiti	perm Depa Impo any i		21. Signature of Funeral S	. V &)			or Street Ba					
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
0. Box 68/60xx	ficate be executed g physician and s the burial-transit	edical Examiner	Sequentially list conditions, The Land Inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
	ath certi attending for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregr in the past 12 month 1 □Yes 2 No 9 □ Unknown		23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal c	death 3	☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су			23d. Date of do	elivery Day Year	
rds, P.	w requires that the de been signed by the should be detached	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confunctions.							to the cause of death? Probably 4 Unknown				
Vital Records,				-				-		24a. Was auto perf 1 ∐Yes		prior to	autopsy findings available completion of cause of	
Vita	Physician: this certific ral director,	Be	25. Was case referred to examiner?	medical	Hospital:			_ Ot	26. Place of Dea					
	or Attending Phy ifter death. Director: After this in by the funeral d	tion: To	27. Manner of Death Natural 5 Pending (Month, Day, Year)				□ ER/Outpatient 3 □ DOA							
Division of		edical Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐ 4 ☐ Homicide	e 28e. Place of Init	Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or 7					n (Street and Number or Rural Route Number, Town, State)				
	To the Hospital within 24 hours of To the Funeral I completely filled													
	To the within 2 To the comple	N.	29b. Signature and title of	certifier	NC				se number			Date signed (Mor		
			1/1/1/1/	1	my	laath ///	00a) /T		7928	1	14/61	rch s	2009	
	, 7		30. Name and address of 24 35 Wes	Va V			Rel	Tim she	mo	2/2)	5			
	Sta	te	31. Date filed (Month, Da		32. Registr	ar's Signatu	ire	5		W . 1 00 1				
	Registr	ar	PU MAR	CUUJ	Lewe	A. 1	CALL COLUMN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland /		rtment of H <i>tificate of L</i>			ene 0 0 9	06602	
T	Physicia	an	1. Decedent's Name (First, Middle, Last	_				2. Date of Death Month February	Day Yea	3. Time of Death 10:30 A M	
*	/Medic Examin		Louis T. 4a. Facility Name (If not institution, give	Cox, Jr.		4b. City, Town, or	Location of Death	li	4c. County of De	120.00 11	
1			5. Social Security Number 6. Se	town 7. Age (In yrs. last	hirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		irthplace (State or Foreign	
ı	Funeral Director		213-09-1300	ØM 2□ F 93	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 10/17/1		country) th Carolina	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	ation				10d. Inside City Limits	
	Ba-f st	Director	MD Baltimo	re C	Catons	ville_		16	Oiline of Miles	1 □Yes 2 No	
	3a or 2	al Dir	10e. Street and Number 719 Maiden Choice	Lane HR 143		10f. Zip Code	1228		g. Citizen of What (US		
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examines must be mailtied at	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		nerican Indian,	
036	urs after al', or i	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates: 1943-4	.6	□Yes 2 No	Specify:		Specify:	White	
15-0	n 72 ho "natur edical	Completed	15. Decedent's Edu (Specify only highest grad	ucation 1 de completed)	6a. Deced	ent's Usual Occupa kind of work done of ONOT use retired	during most of work		6b. Kind of Busines	s/Industry	
212	d withii /giene. er than	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 5-1-		Profess	or		Towson Un	niversity	
and	d be file antal Hy red oth c event	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	•	laiden Surname)		
Maryland 21215-0036	should and Me is mark	2	Louis T. Cox, Sr		19b. Mailin	g Address (Street a		Eason al Route Number,	City or Town, State	, Zip Code)	
e, ⊾	1 and 3 Health em 27 other tr		Mr. L. Thomas Cox,			Shepperd sition (Name of atory or other place			1and 2111		
Baltimore,	Pages nent of ant: If it		1 ☐ Burial 2 ★ Cremation 3 ☐ I	Hemovai from State		etory or other place		/ng E	Baltimore	, Maryland	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be ruitlised at once.		21. Signature of Funeral Service Licens		22.	Name and Addres	ss of Facility Lou	ıdon Park	c Funeral ce, Maryla		
			23a. Part 1. Enter the disease, or composhock, or heart fallure. List only	lications that caused the death. I						Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Esophageol Cancer Ismand Peath Smonth								
				Due to (or as a sonsequence	ce						
F.	ted nsit	Examiner	Sequentially list conditions, if any, leading to miniou at cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ina of):						
0 ,0	ficate be executed physician and s the burial-transit	edical Exar	that initiated events c								
68760,	icate be physici the bu			d							
Box (eath certific attending p for use as t	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3 🗆	Ectopic pregnancy	у		23d. Date of o	lelivery Day Year	
P. O.	that the de ned by the a detached t	Physi	9 Unknown 9 Unknown						23e. Did tobacco use contribute to the cause of death?		
rds,	w requires that s been signed I should be deta	ğ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	on: To Be Completed		11,000				24a. Was an autopsy perform 1 □ Yes 2	prior t	autopsy findings available o completion of cause of ? es 2 □No	
Vita			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	t/Outpation	Othe	26. Place of Deather:	1	nce 6 ☐ Other (Si		
n of			27. Manner of Death 1 □ Natural 5 □ Pending		Bb. Time of Injury	28c. Injury Work	4 LI Nursing no	28d. Describe ho	, ,	овсту)	
isio	I or Attendil after death. Director: A in by the fu	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20e. Place of fillury - At nome	e, farm, stre		Yes 2□No	28f. Location (Str	eet and Number or	Rural Route Number,	
<u>></u>	ital or / irs after ral Dire led in b	Certi	4 Hornicide	building, etc. (Specify)				City or Town,			
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th withir To th comp	Me	29b. Signature and the of certifier	N		29c. License	e number	C A	0d. Date signed (Mo		
	\wedge		30. Name and address or person who d	completed cause of death (Item 23	Ba) (Type, F	Print) L	7/00	7 1	larch	2,2009 01eMD 21228	
	10		31. Date filed (Month, Day, Yeal)	32 Registrar's Signature	7111	Maiden	Choic	eLane	Bultim	01eMD 21228	
	Sta Registr		MAR 0 4 200		ba	de			,		

Funeral Director or 28a-f show traumatic event, the Medical Examiner must be notified at Funeral Director MA or items 23a Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite Baltimore, Maryland 21215-0036 þ Completed Be ဥ injury or other Department of Heal Important: If item 2 any injury or other once. **Physician** /Medical **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Physician/Medical P.0. Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9889 3-17-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** WARREN CHRISTIAN, 23. 2009 1845 **FEBRUARY** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Yrs. 579-50-70 23, 1939 JAN. VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 X Yes 2 No PRINCE GEORGE'S **GLENARDEN** 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20706 USA 7814 FISKE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify Specify: 3 Widowed 4 N Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US ARMY MILITARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALBERTA BOWMAN ALLEN W. CHRISTIAN, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY N. CHRISTIAN / BROTHER 7814 FISKE AVENUE GLENARDEN, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) INCOLN CEMETERY 03-03-2009 BRENTWOOD, MD 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD 20746 DONALD R. GRAY er the disease, or heart failure. List olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each time. shoc Immediate ause (Final disease or condition resulting in death) condition Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) neu IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant copylitions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the companies. 29a. Certifier (Check only one) On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) certifie d cause of death (Item 23a) (Type, Print) PLIST 235 dista

State Registrar 32. Registrar Signat

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Feb. 27, 2009 Toby Dvorkin 0055 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Min Days Hours 1 M 2 X 9/23/1923 Brooklyn, NY 088-12-0760 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d Inside City Limits 10h. County Silver Spring MD Montgomery 1 □Yes 2 No 10e. Street and Number 9039 Sligo Creek Parkway 10f. Zip Code 20901 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No White Specify. 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rosenthal Fannie Skoler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Dvorkin/Son 26 Kilian Drive Danbury, Connecticut 06811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Beth David Cem. 3/01/2009 Elmont, New York 4 ☐ Donation 5 ☐ Other (Specify) ¬ 21. Signature of Funeral Service L PATTT AT THE REPORT OF THE PART OF THE PAR 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiorgan Failure Due to (or as a consequence of): disease or condition resulting in death) Severe Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? metastatic melanoma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 1 □ Yes 2**X** No 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

à

Completed

Be

Funeral

Director

show

28a-f

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23a

, or items

'natural",

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marked other

Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic manners.

death

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

other traumatic event, the Medical Examiner must be notified at

Examine

Physician/Medical

Certification: To

Medical

P Pu burial-transi physician s the burial attending properties as as the ģ signed to has page 2 certificate director this After th funeral

Completed by Be

Physician: The law requires that the death certificate be executed To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

10

State Registrar

2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

5 Pending

1 Tes 2 No

27. Manner of Death

1 XNatural

(Check only one)

29a. Certifier

29b. Signature and title of certifier

Hospital:

28a. Date of Injury (Month, Day, Year)

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

D0063343

Feb. 27, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rubin MD Irina

32. Registrar's Synature

1 Natient 2 ER/Outpatient 3 DOA

28b. Time of

500 Forest Glen Rd. Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Months Days 6782 1 □ M 2 🗹 F Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Gollege (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20659 19a. Informant's Name/Relationship (Type. Print) DVORAK 37009 WST 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 4 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or how failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thero scienotic Cardio Vasular ditease Due to (or as a consequence of) Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Advonce Dementico Recent Preumonia 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Aspiration 2 No 219 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 1 | Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident

Division or Vital Records, P.O. Box 68760, C. Ior Attending Physician: The law requires that the death certificate be executed after death. within 24 hours after death.

To the Funeral Director: /

Physician /Medical

Examiner

Funeral

Director

ms 23a or 28a-f shor must be notified a

the Medical

Completed by Funeral Director

Be P

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

in by 1

and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show

Health a

permit. Pages 1 and Department of Healt Important: If item 27 any injury or other i or other

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

9 ☐ Unknown	9LUnknown	
art II. Other significant condition	ns contributing to death	but not resulting in
A	-	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

6 Could not be determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifier 50653

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 3-3-2009

GYAN. C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road. Deale

5851 Deale 31. Date filed (Month, Day, Year)

3 ☐ Suicide

4 Homicide

Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:20 Ruby Ann Douglas 2009 February 23, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Genesis- Perring Pkwy Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 67 01/08/1942 220-36-4440 Baltimore, MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Parkville MDBaltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 1801 Wentworth Road U.S.A. by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) 1 2 College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Mangary Injury or other traumatic event, The Mangary Clerical Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frankgeter Parish John Bailey ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valley Arbor Ct. Apt. H Essex, MD 21221 Harvey L. Bailey/ Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/03/09 Parkville, MD Parkwood Cemetery 4 Donation 5 Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardy **Physician** /Medical Due to (or a a consequence of): **Examiner** ronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 🗍 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 🔀 Natural eral Director: A filled in by the fi 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide e Funeral 29a. Certifier 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 02 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Α. Compton Gregory 6095 Marshall Drive Elkridge, MD 21075 MD31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

AMEND #8 PER FH G889 3/12/09 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2032 Roslyn Jane Denmark Jarc /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, 1950 4 Hrs. Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday, **Funeral** Months Days Hours 1 □ M 2 □ XF 218-60-4963 Director 17 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at **Funeral Director** 1 Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 238 North Bethel Ct. 21231 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Self-Employed 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental I Carolyn Denmark ၉ Jerome Spence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Ervin-Daughter 4612 Parkton Street, Baltimore, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 3/9/09 Woodlawn, Md 21. Signature of Funeral Service Licensee March FTH West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications the caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran P.O. Box 68760, signed by the attending physician dbe detached for use as the burial Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown ngt resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was **a**n this certificate has page 2 autopsy performe 2 No 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient After thi funeral 27. M nn of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: , completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapped stated. 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year, of death (Item 23a) Year State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1, 7:20AM John Ferdinand Dex March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Silver Spring
If Under 1 Year | If Under 24 Hrs. | 8, D Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director February 11, 1927 Washington, D.C. 579-30-9781
Usual Residence of Decedent 82 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Experimental Property. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20851 Funeral 709 Marshall Avenue <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: 3 3 X Widowed 4 ☐ Divorced WWII White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Family Owned College (1-4or 5+) Elementary/Secondary (0-12) Service And Sales Appliance Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Max Joseph Dex <u>Albertina Schilling</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert F. Dex/ Son 709 Marshall Avenue Rockville, Maryland 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State March rark Cemetery: 5, 2009 | Baltimore, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Puneral Service Licensee M00335 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Advanced Dementia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Living 1 ☐ Yes 2 🛣 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D24035 March 2, 2009

Registrar
DHMH 17 Rev 1/2001

State

3110 Gracefield Road, Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugenio S. Machado,

MAR 0 4 2009

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

Certificate of Death

Wheaton

If Under 1 Year Months Days

7. Age (In yrs. last birthday)

10c. City, Town or Location

86

4b. City, Town, or Location of Death

2. Date of Death Month

March 2,

Apr.3,

Hours Min. 8. Date of Birth (Month, Day, Year)

2009

4c. County of Death

10g. Citizen of What Country?

Montgomery

PA

14. Race - American Indian,

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Construction

20c. Location - City or Town, State

23d. Date of delivery

Month

Alexandria, VA

20902

3. Time of Death

1:30 P M

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

4845

Year

ONE

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 28 No

2 No 3 Probably 4 □Unknown

1 ☐ Yes 2X No

Physician /Medical Examiner Decedent's Name (First, Middle, Last)

R

10b. County

3006 Hardy Avenue

5. Social Security Number

180-16-8121

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

1 3 M 2 ☐ F

Funeral Director

deeth with the Maryland in then "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at

> 10 State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certific



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Bethesda, MD 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 28 2009 **Physician** WALTER DORN 5:11 A M /Medical 4a. Facility Name (If not institution, give street and number) 4h. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. BALTIMORE TOWSON Hours Min. 8. Date of Birth (Month, Day, Year 10/07/1926 If Under 1 Year 9. Birthplace (State or Foreign Country)

NY 5. Social Security Number 7. Age (In yrs. last birthday) Funera! Days 104-20-1320 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6350 RED CEDAR PLACE, #200 21209 USA by Funeral Baltimore, Maryland 21215-0036 $\, \mathcal{O}_{\cdot}$ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE EXECUTIVE **INSURANCE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f Mental ISAAC DORN YETTA ZIENCE ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Fages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. LAURIE MARGOLIES / DAUGHTER 6612 CHELWOOD ROAD, BALTIMORE, MD 20a. Method of Disposition Date 20c. Location - City or Town, State ARCOINGY ON ACHT ZUKOLACE) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AMUNO CONGREGATION 03/02/2009 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Men Ce 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-trans law requires that the death certificate be exect Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 W Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 X No Hospital or Attending Physiclan: The P 24 hours after death. Funeral Director: After this certificate h certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 🔼 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

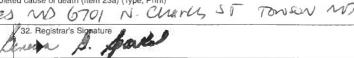
| Comparison of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

20

State Registrar

AARO 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



February 28 2009

State of Maryland / Department of Health and Mental Hygiene 06611 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month Day **Physician** 7: K A M **DOBRES** LEON March 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Ballimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 01/23/1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex D 1 X M 2 □ F **Funeral** Months Days Hours Min. 87 216-14-4843 MD Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fre facility for the traumatic event, fre facility to the traumatic event, fre facility for the page 18 any injury or other traumatic event, fre facility and the facility of Director 1 ☐ Yes 2 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 809 HOPEWOOD ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No ARMY If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 □Yes 2 X No Specify: Ď 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES FURNITURE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ISRAEL DOBRES NETTIE NELSON ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 HOPEWOOD ROAD, BALTIMORE, MD IRENE DOBRES / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State BOBROTSKER BENEFICIAL 03/03/2009 CIRCLE LODGE 1 X Burial 2 Cremation 3 Removal from State ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sender Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi requires that the death certificate be execu Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. W*a*s an Jas autopsy certificate performed' 1 ☐ Yes 2 ☑ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1- Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.B.B.S RES-000 March, 1,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AGRAW ML Sinai KIREET 31. Date filed (Month, Day, Year) State Registrar

Debres, Leon

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 06613 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MARCH 10 35 AM S EAGLE BETTY \odot 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITA BALTIMORE AGNES Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 08/18/1915 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours 216-32-0783 94 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No N/A MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 7015 WALLIS AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify δ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than 'r any injury or other traumatic event, It a INVA once. College (1-4or 5+) 5+ Elementary/Secondary (0-12) NURSE NURSING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **SMALL** ROSE ROSENTHAL HYMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1177 HARBOR OAK DRIVE, CROWNSVILLE, MD 21032 SALLY CARLEEN / DAUGHTER 20b. Place of Disposition (Name of ARLINGTON CHIZUK AMUNO CONGREGATION 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify 03/03/2009 BALTIMORE, MD 22. Name and Address of Facility of Funeral Servi SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RENAL **Physician** 2 WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PAN CREATITIS Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ONGESTIVE YEARS attending physician and for use as the burial-tran Due to (or as a consequence of) ME TABOL Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) nis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 1 ∐Yes 2**Y**⊊No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated

P.O. Box 68760, Hospital or Attending Physician: 24 hours after death.
Funeral Director: After thi etely filled in by the funeral

Baltimore, Maryland 21215-0036

within 24 ho

To the Fune

completely f

State Registrar 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

KWAME

2009.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATON BALTIMORE 21229

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March George Gerard 03^{ay} 2009^{ar} Fuchs 3:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 04; 5. Social Security Number Sex 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1918 Months 04, 212-05-7720 90 Director MaryTand Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or items 23a or 28a-f sho Director Md. Carroll Manchester 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2570 Mindi Drive 21102 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s any injury or other traumatic event, the "Notical Evantinal runst gonge. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🖾 No Yes, Give Specify. Š Specify: White 3 X Widowed 4 ☐ Divorced Ye ar or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Fuchs Elizabeth Grandlund ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cecilia Fedarcyk/ Daughter 2570 Mindi Dr. Manchester, Md. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer 3-7-09 Baltimore, Md. 21. Signature of Funeral Service License Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ementa /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurral-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 □Yes 2 1 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Yes 2 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ADVE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred LOWSE 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 4 2009

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DHMH 17 Rev 1/2001

npleted cause of death (Item 23a) (Type, Print)

Kan

Malcolm Daire, Westminster My

Physicia /Medic Examin

Funeral Director

1 - State Registrar			Ce	rtificate of L	Death		Reg. No.	2009	06613	,
Decedent's Name (First, Mi	iddle, Last)					2. Date of D	eath		3. Time of Death	
John	Ullrich		G	oodman		Februa	rv 26	Year 5,2009	4:00 p ^M	
				T	Location of De					
5 Arrowshir	o Road			D	undalk			Balti	nore	
5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign	
212-30-9314	1 ∑ M 2 □ F	7	б Yrs.	Months Days	Hours IV	Decumber	c 19,19	32 Mar		
Usual Residence of Decedent										
	•	10c. City								
Maryland Bal	timore		טע							
	7				222	10g. Citiz	10g. Citizen of What Country?			
5 Arrowship R										
11. Marital Status	Armed Fo	rces?								
	If Yes, Gir	ve		1 □ Yes 2X No	Specify:			Specify: Whi	te	
		ates.	16a. Dece	dent's Usual Occupa	ation					
(Specify only hig	ghest grade completed)	4== 5 - \	(Give	kind of work done d	luring most of	working			,	
	2) College (1	-40r 5+)	Mil	lwright			Ste	eel		
	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middl	e, Maiden	Surname)		
James Goodman					Rosin	e Sartor:	ius			
								r Town, State, Zip	Code)	
Kathy Wilson	Daught	er	6803	Dunhill R	load, D	undalk,Ma	aryla	nd 2122	2	
20a. Method of Disposition	• II D	20b. PI	ace of Dispo metery, crei	osition (Name of matory or other place	e) Mar	ch ^{Date} 3,				
							Balt:	imore, M	aryland	
21. Signature of Funeral Serv	ice Licensee	. 01	1 2	2. Name and Addres	s of Facility	Home Of	Dunda	alk D A		,
ming	my Con	mele	\mathcal{G}	7110 Solle	ers Poi:	nt Road,	Dunda	alk,MD.	21222	
23a. Part 1. Enter the disease shock, or heart failure. I	e, or complications that c List only one cause on e	aused the death	Do not en	ter the mode of dying	g, such as can	diac or respiratory	arrest,		Approximate Interval Between	
Immediate Cause (Final disease or condition										
resulting in death)			J.			, , ,			7 - 1,1 - 2	,
Sequentially list conditions	b. CIE	ARRE'	tte.	SMOKI	19 H	4P Celip	DEMI	A		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
that initiated events	c. Due to	DEN JEN	17 WH	, KENAI	INDA	humig				
resulting in death) Last Due to (or as a consequence of): /										
	d									
IF FEMALE:	23c. If yes, out	come of pregnar	ncy				2	3d Date of deliv	en/	
in the past 12 months?					′		-	Month	Day Year	
9 Unknown	9 🔲 Unkn	own								
Part II. Other significant cond	ditions contributing to de	eath but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did	l tobacco us	se contribute to t	he cause of death?	
RENAL INSUFF	· LENCY ,	HUPER	TENS	WN, CA	D	11x	Yes 2]No 3 ☐ Pro	pably 4 ☐ Unknown	
	/ /	, ,		,		24a. Wa	s an	24b. Were auto	ppsy findings available	
						— l aut	opsy formed?	prior to co death?	mpletion of cause of	
					26 Place of	1 ☐ Yes Death (Check only		1 □ Yes	2 L No	-
25 Was case referred to med	lical							5 □ Other (Speci		
25. Was case referred to med examiner? 1 □ Yes 2 1 No	Hospital:	Innationt 2 🗆 I	=B/Outnatie	nt 3 DOA Othe	r: A D Nurein	a Homo EN Po			6.4	
examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 🗆	of Injury	28b. Time o	f 28c. Injury	4 □ Nursin	g Home 5 KRe			fy)	
examiner? 1	Hospital: 1 🗆	·		f 28c. Injury Work	4 □ Nursin	-			(fy)	
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	4a. Facility Name (If not institute 5 Arrowship 5. Social Security Number 212-30-9314 Usual Residence of Decedent 10a. State 10b. Coum Maryland 10c. Street and Number 5 Arrowship R 11. Marital Status 1 Never Married 2 May Widowed 4 Divor (Specify only high Elementary/Secondary (0-1 11 Years 17. Father's Name (First, Midd James Goodman 19a. Informant's Name/Relatification 5 Other 1 Signature of Fune 1 Serve 1 Signature of Fune 1 Serve 1 Signature of Fune 1 Serve 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Sequentially Pes 2 No 9 Unknown	4a. Facility Name (If not institution, give street and numerical Security Number 212-30-9314 6. Sex 212-30-9314 1	4a. Facility Name (If not institution, give street and number) 5 Arrowship Road 5. Social Security Number 212-30-9314	4a. Facility Name (If not institution, give street and number) 5 Arrowship Road 5. Social Security Number 212-30-9314 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10c. City, Town or Load Individual Park (Individual) 10c. Street and Number 5 Arrowship Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 years 17. Father's Name (First, Middle, Last) James Goodman 19a. Informant's Name/Relationship (Type. Print) Kathy Wilson Daughter 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeyl Service Licensee Algority only leading to immediate cause. Enter Underlying Cause (Final disease or conditions; if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) 1 FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the but not resulting in the past 12 months? 1 Yes 2 No 9 Unknown	4a. Facility Name (If not institution, give street and number) 5 Arrowship Road 5. Social Security Number 212-30-9314 1 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. State 10b. County 10c. City, Town or Location 10d. State 10b. County 10c. City, Town or Location 10d. Street and Number 5 Arrowship Road 11. Marital Status 1	4a. Facility Name (If not institution, give street and number) 5 Arrowship Road 5. Social Security Number 212_30_9314 1212_30_9314 1222	4e. Facility Name (if not institution, give street and number) 5 Arrowship Road	46. City, Town, or Location of Death 5 Arrowship Road 5. Social Security Number 212-30-9314 6. Sex 10 M 2 F 7. Age (in yrs. last birthday) 212-30-9314 10. City, Town or Location Maryland 8 Baltimore 10. City, Town or Location Dundalk 10. Street and Number 21222 11. Marital Status 12. Wiss Decedent Ever in U.S. 13. Was Decedent of Hapanic Origin? (Specify Yes or No-Hers, Specify Cuber, Merican, Puerto Rican, etc.) 14 Yes, Give Yes or Otales: 15. Decedent's Education (Specify only highest grade completed) 16. Street shall be considered and status (Specify only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Informant's Name/Reliationship (Type, Print) Sath Wilson 19. Informant's Name/Reliationship (Type, Print) 19. Informant's Na	4e. Facility Name (If not institution, give street and number) 5. Arrowship Road 12. 30-9314 12. Was Decedent 10c. City, Town or Location 10c. City, Town or Location 10c. State 10c. City, Town or Location 11c. Marital Status 11c. Was Decedent Ever in U.S. 11c. Was Decedent Vision Ever in U	46. Earlilly Name (if not institution, give street and number) 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Social Security Number 10. Size of the Social Security Number 5. Sharrowship Road 11. Marial Status 12. Was Decedent Ever in U.S. Was Decedent of Helphanic Chipir (Specify Yea or No Vise Code) 13. Nee Decedent of Helphanic Chipir (Specify Yea or No Vise Code) 14. Baca - American Indian, Specify Was or No Vise Code (Specify Vise) 15. Nee Decedent of Helphanic Chipir (Specify Yea or No Vise, specify Was or No Was or

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 the Hospital or Attending Physician: The law requires that the death certificate be executed Certification: Within 24 hours and To the Funeral Dir 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated Daru 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BOTARU Pebruary 27,2009 DO067271 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VALERIU 200 MEMORIAL AVE, WEST MINST CEBOT 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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09-01009 UNK UNK			Please Type of the in Black Indelible Ink. Ensure All Coasts Are Legible. State of Maryland / Department of Health and Mentallygiene
		ا	- For State Certificate of Death Reg. No. 2009 Ubb 1
Ph V∽⊲ ical E	ysicia xamir	-	1. Decedent's Name (First, Middle Last) 2. Date of Death Month Day Year February 3, 2009 3. Time of Death 1524 hrs
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
.			31 S. Payson Street Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
	neral ector		215-86-9920 1 M 2 F 40 Yrs. Months Days Hours Min. June 15, 1968 Manyland
	any	`	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
land	-f show	ξ	Manyland N/A Battimore 1 Les 2 No
MD 21215-0036 Solould be filed within 72 hours after death with the Maryland hand Maryland		Il Director	10e. Speet and Number 10f. Zip Code 10g. Citizen of What Country? 10f. Zip Code 10g. Citizen of What Country? 10f. Zip Code
ath wit	or items 2 must be r	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after de	al", or		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: Specify:
hours	"natur Exami	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)
036 ithin 72	r than ledical	Completed by	10 Prep Cook Restaurant
21215-0036 uld be filed within 7 Mantal Haviens		Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Brenda Coates
D 21 should b	7 is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Box 3354 Baltimar, Manskyd 2213
e, MD	item 2	ł	20a. Met d of Disposition
MOF	r other		1 Journal 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other specify: At 20 Cemetry 2/28/09 Landsdown Maryia 1
Baltimore, permit Pages I at	Important; If item 27 is n injury or other traumatic	Ī	21. Signature of Fun all Service Licensee 22. Name and Address Pacility Pure Fungal Home 4.21229
Physi		1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft proximate Interval
and the second	dical		failure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis of the liver
			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions b. Chronic alcohol abuse and hepatitis C Infection
		<u>a</u>	Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause
	.=	xaminer	C. Due to (or as a consequence of):
executed	After this certificate has been signed by the attending physician and inneral director, page 2 should be detached for use as the burial - transi	cal E	X UNPENDED AMENDED PI line a-b, PII,27,perME, g891 5/15/09 TT
	hysicia e buria	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Records, P.O. Box 68760, The law requires that the death certificate be	nding p se as th	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box e death	the atte	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown
P.O. es that the	ned by detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic obstructive pulmonary disease.
ds, l	een sig		Chronic obstructive pulmonary disease 1 Yes 2 No 3 Probably 4 ✔ Unknown 24a. Was an 24b. Were autopsy findings available
SCOF le law r	te has b ge 2 sh	Completed	autopsy performed? performed? prior to completion of cause of death? 1 \(\nsline \text{Yes} 2 \) No 1 \(\nsline \text{Yes} 2 \) No 1 \(\nsline \text{Yes} 2 \) No
	ertifica ctor, pa	Be Co	25. Was case referred to medical 26.Place of Death (Check only one)
f Vit	r this c	일	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 V Other: Scene
on o' nding l	r: After t		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Division of Vital Records, pital entending Physician: The law requirements of the charter of the	eral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Dj.	Funeral I	팅	4 Homicide determined (Specify)
- V - + -	To the Fu	Medical	(Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
OL WA	2 3	Ě	and manner stated, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			(M.E. February 4, 2009)
Orpend	$\sqrt{}$		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Regist		MAR 0 4 2009 Server S. Jak
DHMH 17 I OCME 200		101	ŐRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician -Month - LDT VAR 40 TOW /Medical 5,2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deat naryland tal altimore 5. Social Security Number **Funeral** 6 Sex ge (In yrs. last birthday) TUnder 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign New York) Date of Birth (Month, Day, 1 M 2 □ F Months 101-18-710 Days Hours Min. Director Usual Residence of Decedent the Maryland 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar is ust be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 2/229 11. Marital Status . Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married □Yes 2 □ N If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: marked other than "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INKNOWN 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ၉ 20WY LnKi 70WM 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is a ran 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD 21207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician resulting in death) /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the burial-transi and Due to (or as a consequence of): physician Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) Month Day Year the 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No certificate has page perform 2 No 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Yes 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient After this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Records, P.O. Division of Vital filled in by

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

within 24 hours after death. To the Funeral Director: completely

Medical

State

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29b. Signature and title of certifier oli lanen

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 0 4 2009

Certificate of Death

2 Date of Death

F Month

279 ay 200 Year

4c. County of Death

Carroll

U.S.A.

Farming

14. Race - American Indian, Black, White, etc.

Specify: White

9:27 p

9. Birthplace (State or Foreign Country)
Penn

10d. Inside City Limits

1 ☐ Yes 2 No

/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 1, 5. Social Security Number 218–40–1124 7. Age (In yrs. last birthday) 6. Sex 1 M M 2 □ F Funeral Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinat 5 ust be notified at Manchester Maryland Carroll Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21102 2815 Tracey's Mill Rd. 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1-1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □No If Yes, Give 63-1965 Year or Dates: 63-1965 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willard Daniel Hoff Hilda Alverta Leese ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other training. Rose Marie Hoff - wife 2815 Tracey's Mill Rd. Manchester, MD. 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State New Lutheran Cem. March 3,2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Seth Ella 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CROTALY **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760 Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by NITUCULAR TACKY CARDIA Maric OBSTRUCTUSE DUMPICUS 24a. Was an 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide determined 4 ☐ Homicide

Manchester, MD. 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Approximate Interval Between Onset and Death IUIL 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Was a autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D31640 03/02/2009 Arenie MARY(A) WES MID STEN

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 0 4 2009

29a. Certifier

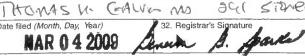
(Check only one)

29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last)

Donald W. Hoff

Physician



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

age STENRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 2253 M James Alexander Heard, Jr February 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 M D 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Min. **1** M 2□ F Months Davs Hours 6-4-1955 Director 216-62-6653 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Inc Medical Examinar must be notified at Yes 2 No Director MD Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1617 W. Baltimore Street 21223 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedon. _ Armed Forces? 1√_Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married 1√Yes 2☐ If Yes, Give Year or Dates: 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Alexander Heard, Sr Julia Mae Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt 1617 W. Baltimore Street Balto, MD 21223 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Linda Heard-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-5-2009 Owings Mills, MD Garrison Forest 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 l an Wane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart hree months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or darning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. detached 9 Unknown 9 Unknown ò certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Chole 14stitis 4 Unknown 2 No 3 Probably 1 □ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Hyps thermia autopsy performe 1 ☐ Yes 26. Place of Death (Check only of director, 25. Was case referred to medical Be examiner? Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3 DOA 1 Inpatient After this of funeral din Certification: To 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending Patter death. 1 Natural 2 ☐ Accident 5 Pending Within 24 hours are
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MA DEA BL9916795 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 Meghan Checkiey 900 south caton Avenue Baldmore Maryland 32 Registrar's Signature 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death SEV 260 4a. Facility Name (If not institution, give street and number) 4b. City, Town, o Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Months M 2 F 54 213-62-9243 December 19,1954 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 No Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 8102 N. Boundary Road 21222 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔥 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀No If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Loyd Henry Sr. Hedwig Kahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Henry Brother 9517 Holiday Manor Road, Perry Hall Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State March 3, Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore City, Md. 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, 7110 Sollers Point Road, Dundalk, se, or complications that caused the death. List only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. L not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final METABOLIC AUDOSIS disease or condition resulting in death) Due to (or as a consequence of) SEPSIS Sequentially list conditions, if any, leading to mare duate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, PERICARDIAL Due to (or as a consequence of) METASTATIC NON SMALL COLL LUNG CANCER 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery Ectopic pregnancy 3 Month Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 🗌 No 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 🗌 Yes 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) Hospital 6 ☐ Other (Specify)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, ding physiciar the

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signed by

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certificate

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After

death.

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

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Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed Be 2 Certification: D rector A within 24 hours at To the Funeral Discompletely filled Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical examiner? Other: 4 \square Nursing Home 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence Manher of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 🔲 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and 29d. Date signed (Month. Day. Year)

f death (Item 23a) (Type, Print) 30. Name and addre ompleted cause ran

600 North Wolfe St, Baltimore, MD, 21287

State Registra

2

31. Date filed (Month, Day, Year, MAR 0 4 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3/1/2009 **Physician** A^{M} 5:00 Kamalavathy Harris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Manor Care Woodbridge Valley If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/31/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🏻 F 85 India 220-50-3215 Director Usual Residence of Decedent 10d, Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be redflied at 1 ☐ Yes 2 No Director Upper Marlboro Prince George 10f. Zip Code 10g. Citizen of What Country? -10e. Street and Number USA 20772 14501 St. Thomas Church Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Native American Completed by 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Spring Grove Hospital Social Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be Nilorpalam Gnanasironmani James E. G. Arthur 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar 14501 St. Thomas Church Rd., Upper Marlboro, MD 2077 Department of Health Important: If item 27 any injury or other tr Mr. Prem Harris/Son Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/7/2009 Baltimore, MD Resurrection Acres 21. Sign atule of Funeral Service Lic-22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1212 W. Old Liberty Rd., Winfield, MD 21784 Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** 2 HEIMER'S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □Yes 2 ☑No 4 Pregnant at time of death 5 Other (specify) P.0. signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, CARDIOVASCULAR 1 Tes 2 No 3 Probably 4 Unknown MYPERTEN SIVE Completed 24b. Were autopsy findings available prior to completion of cause of death? TYPE 24a. Was an cate has t page 2 s performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D 0059107 03-02-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIVE REISTERSTOWN MD 21136 BUSINESS STER 210 CEN 31. Date filed (Month, Day, Year) State MAR 0 4 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 28, 2009 **Physician** 2:00 P. M Leah Hiebert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford County Bel Air 261 1/2 Wakely Terrace 8. Date of Birth (Month, Day, Yea Sept. 21, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1^{Year)}1909 **Funeral** Months Days Hours Min Alberta, Canada 1 □ M 2 52 F 122-30-8683 99 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b County 10a State 28a-f show if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examinat is ust be notified at Bel Air 1 ☐ Yes 2 X No Maryland Harford County Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 261 1/2 Wakely Terrace United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 □ Yes 2√No Specify. à 3 Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Artist Artistry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helena Loewen Cornelius Penner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Dennis Hiebert (Son) 261 Wakely Terrace, Bel Air, Maryland 21014 nt of Health a t; If item 27 is 7 or other trau Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Shenandoah Memorial Park March 9, 2009 Shenandoah, Virginia 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State Department of Important; If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Service-BelAir 21. Signature of Funeral Service License 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. YPERTENSION Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HERNIA HIATAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CARDIOVASCULAR ARTERIO SCLEROTIC physician and the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Millinknown 9 Unknown been signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 ☐ Nursing Home 5 Nasidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred funeral 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760, s after death.

I Director: A in by the fu

Baltimore, Maryland 21215-0036

within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of certifier

SYED F. MAHMOOD M.D. 2227 OLD 31. Date filed (Month, Day, Year)

unni

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Degistrar's Signature

and manner stated.

EMMORTON ROAD SUITE 212 BEL AIR

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

MARCH 2, 2009 MARYLAND

	•	For State Registrar	State of Ma	aryian		artment of H			Reg. No. 2	009	06624
Physici /Medi		1. Decedent's Name (First, Middle, Dorothy E. Ho						2. Date of De		Year 200	3. Time of Death
Examir		4a. Facility Name (If not institution)	give street and number)	1 Ce	nter	4b. City, Town, or	Location of Deat	son	4c. Co	ounty of Death	ltimore
Funeral Director		220-20-3376	6. Sex 7. Ag		la <i>st birthd</i> ay) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, D January	rth ay, Yea <i>r)</i> 13 , 192	9. Birth Con Mary	nplace (State or Foreign untry) yland
iand ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
e Mary la-f sh	ctor	Maryland Baltimon	æ	Phœ	nix						1 □Yes 2X No
with the	Director	10e. Street and Number 12510 Jarrettsville	Dika			10f. Zip Code 21131		10g. Citizen of What (untry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mentai Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Medical Examin or must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie	12. Was Decedent Armed Forces?	•	1	Was Decedent of H If Yes, specify Cuba		pecify Yes or No o Rican, etc.)		Race - Amei Black, White	
permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, If a Medical Examinance.	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀 No dent's Usual Occup	Specify:	16b K		oec <i>ify:</i> Whit of Business/I	
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should be tnd Mental s marked o	2	Harry Boss 19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (Street	Grace Sour and Number or R		ber, City or T	own, State, Z	lip Code)
l and 2 sho Health and I'm 27 is ma		Patti Ieland - Daug			12510	Jarrettsvi.	lle Pike, 1	Phoenix, N	⁄arylan	E1131	
Pages 1 a nent of He int: If item iry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 ☐ Removal from State		Place of Disponentery, cre	osition (Name of matory or other place metery	^{ce)} 2/28/	Date 2009		tion-City or 1 Lle, Mar	
permit. Page Department Important: I any injury o		21. Signature of Funeral Service L	icensee	ema	() E	vanis Fundada 800 Harford	Poad, Pard	Crematic wille, Ma	n Servic aryland	es - Pa 21234	rkville
Cate be executed by physician and physician and physician and the burial-transit	Examiner	23a. Part 1. Enter the disease, or shock or flear failure. List of the control of	a. Due to (or as	ONIF	quence of):	ter the mode of dyir	g, such as carola	c or respiratory	arrest,		Approximate Interval Between Onset and Death DAYS
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 19 months? 1 Yes 2 No 9 Unknown	d	2 Feta at time of	al death 3 death 5	□ Ectopic pregnanc □ Other (specify) □		23e. Did		d. Date of del Month	ivery Day Year
quires tl en signe uld be c	ed by		To continuous g to doubt						Yes 2		obably 4 🗌 Unknown
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sician certifi rector	B B	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	iont OF	TED/Outpotic	ent 3 DOA Oth	26. Place of De	ath <i>(Check only</i> Home 5□ Res		Other (C	
ding Phy. h. After this funeral di	tion: To	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury	28b. Time a	of 28c. Injur Wor		28d. Describe			спу)
after deat Director: d in by the	ertifica	1 Yes 2 No							(Street and i	Number or Ru	ıral Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical C	29a. Certifier Certifyin (Check only one)	g Physician: To the best Examiner: On the basis and manner s	of examin	owledge, dea ation and/or i	th occurred at the ti nvestigation, in my o	ime, date and place opinion, death occ	e, and due to th urred at the time	e cause(s) a e, date and p	nd manner as lace, and due	s stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	1	0		29c. Licens	se number			signed (Monti	
		· (eVal	Up, M	V			886		Fel	orua:	y 26-0
5		30. Name and address of person	/								-
		LILIA CEBALL 31 Date filed (Month, Day, Year).	05, M.D.	76 ZI	1 OSL	ER DRIV	E TOWS	ON, MAR	YLANI	2120	14
St Regist	ate trar	31. Date filed (Month, Day, Year)	2009	w	B. A	land					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Malcolm John February 3:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign 5. Social Security Number Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 29, 1926 New York 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X** M 2□ F 82 090-20-6089 Director Usual Residence of Decedent with the Maryland 10b County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8300 Fenway Road 20817 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1944-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify. White Specify: ò 1946 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) New York College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher/Guidance Counselor Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Lord Head Mary Emma Lucid 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doris F. Head / Wife 8300 Fenway Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State March 2, 2009 Montgomery Crematorium, Inc. Bethesda, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Fun al Service Licensee 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) e attending physician and for use as the burial-transi Exami Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Urinary Tract Infection, Renal Dysfunction, Anemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Sepsis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No page 2 s autopsy ormeg? 2∭No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) s after death.

Director: After this ce in by the funeral direc 1∐ Yes 2⊠ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 A Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital completely filled

within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

Box 68760

Records.

Vital

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Division

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State

Registrar

31. Date filed (Month, Day, Year) MAR 0 4 2009

Eric J. Park, M.D.

29a. Certifier

29b. Signature and little of

8600 Old Georgetown Road, Bethesda, Maryland 20814

and manner stated.

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060117

29d. Date signed (Month, Day, Year)

February 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06626 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Ye ar 27, 2009 1:40 PM Anna Mary Hollar February 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Essex
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Riverview Nursing Center Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3/12/1912 1 □ M 2 🖵 F 216-36-4914 96 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7716 North Point Creek Rd. 21219 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2\(\times\)No Specify: Specify: White 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Baum Alice Shaub 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Mazurek Granddaughter 3810 Clarkspoint Rd. Middle River, MD 21220

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f show Evanings must be notified at Health and Mental Hygiene. em 27 is marked other than "natui other traumatic event, in Medical item 27 r other t Department of I Important: If its any injury or o once.

Baltimore, Maryland 21215-0036

Physician

Examiner

Funeral

Director

/Medical

10a. State

Director

Funeral

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Completed

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Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar attending physician for use as the buria signed by the a icate has been siç , page 2 should b

Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition	10	20b. Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City o	or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Oak Lawn	Cemetery	3/4/2009	Baltimore,	Maryland
	21. Signature of Funeral Service Licer	see	D	Name and Address of Fauda-Ruck Fun	eral Home o		
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	he death. Do not ent	922 Wise Ave er the mode of dying, such	as cardiac or respiratory	Maryland 212	Approximate Interval Between Onset and Death
xaminer	Sequentially list conditions, if any, leading to him sure cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):				
dical E		d.	consequence of):				
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of do Month	elivery Day Year
	Part II. Other significant conditions of	ontributing to death but		nderlying cause given in Pa	1.0	d tobacco use contribute	to the cause of death? Probably 4 Unknown
Completed by		_			24a. Wa au pe 1 □ Yes	topsy prior to death?	autopsy findings available o completion of cause of s 2 100
8	25. Was case referred to medical examiner?	Hannital:		0.0	ace of Death (Check only		
2	1 Yes 2 No		t 2 ER/Outpatien		Nursing Home 5 ☐ Re	esidence 6 Other (Sp.	ecify)
ation:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2		e how injury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location City or 7	(Street and Number or F own, State)	Rural Route Number,
edicai	29a. Certifier 1	ysician: To the best of niner: On the basis of and manner state	examination and/or in	n occurred at the time, date vestigation, in my opinion, o	e and place, and due to to death occurred at the time	ne cause(s) and manner are, date and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and little of certifier	1-D		29c. License number	7-7-54	29d. Date signed (Mon	
	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, I	EAST BRA	BLVD.	MD-	21221.

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2009

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a, perInf 6889 3/24/09 TT
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 06627 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death

Physician /Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physicia /Medica Examine

Funeral Director

Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed

The state of the s	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		To the Funeral Director: After this certificate has been signed by the attending obvicion and
O Land The	completely filled	o file i diletal i	To the Ermorel

Division or Vital Records, P.O. Box 687605

n il	CORA MA	AE HINES						FEBRUARY	28 ,	Year 2009	2:08 A M
r	4a. Facility Name (II	f not institution, give	street and numi	ber)		4b. City, Town, o	or Location of Deat	h		nty of Death	
		OSS HOSPIT				SILVER				TGOMER	Υ.
	5. Social Security N		x ⊐M 2∏∑F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign ntry)
	244-48-2 Usual Residence of	2752		78				JUNE 28.	1930	NC	
	10a. State	10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
ō	DC			T.7 A	CHINCT	ON					1 X Yes 2 □ No
co	10e. Street and Nur	mber		WA	SHINGT	10f. Zip Code		1	0g. Citizen o	of What Coun	itry?
2	721 CONG	GRESS STRE	EET. SE			20032			USA		
Funeral Director	11. Marital Status		12. Was Deced	lent Ever in U.	S. 13. \		lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. F	Race - Americ	
7	1 ☐ Never Marri	ied 2 ∑ Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	2 🔀 No		il Yes, specily Cub. 1 □ Yes 2 🛛 No		to riican, etc.)		Black, White,	etc.
o c	3 ☐ Widowed	4 ☐ Divorced	Year or Dat	les:		ILLIES ZENINO	эреспу.		Spe	BL.	ACK
ere	(Spec	15. Decedent's Educify only highest grad	ucation de completed)		16a. Deced (Give	dent's Usual Occup kind of work done	oation during most of word)	rking	16b. Kind of	f Business/Inc	dustry
Completed	Elementary/Seco	ndary (0-12)	College (1-	4or 5+)							
3	12TH	(First, Middle, Last)			DOME	STIC ENG		me (First, Middle, i		VATE	
o Re	JOE DIXO							SPEIGHT	vialderi Surr	amej	
۲ ا			îvne Print)		19h Mailir	na Address (Street		ural Route Number	City or Toy	un Stata Zin	Codel
- 1		ame/Relationship (T	_	A NIT			STREET.				
8	20a. Method of Disp		JR/ HUJD	20b. P	lace of Dispo	sition (Name of	1		INGTO	n - City or To	20032 own, State
		☐Cremation 3 ☐: 5 ☐ Other (Specify				natory`or other pla FMORTAT. T	PARK 03-0	27_2000	T ANDO	OTED M	D
		neral Service Living		1				ARSHALL'S		VER, MI	
	M	KCX	DONALD	R. GR	AY		UITLAND H		ITLAN		20746
	23a. Part Enter th	he disease o comp irt failure. Vi conly c								, 110	Approximate Interval Between
	Immediate Cause ((Final									Onset and Death
- 1	resulting in death)			IRATOR or as a consequ		UKE					
	0		b. STRO	KE							
ner	Sequentially list con if any, leading to im cause. Enter Unite	nmediate		r as a consequ	uence of):						
Examiner	Cause (Disease or that initiated events resulting in death) I	injurý	U	RTENSI							
	resulting in death) i	2431	Due to (o	r as a conseq	uence of):						
cian/Medical			d								
/Me	IF FEMALE:		23c. If yes, outco	ome of pregna	IDCV						
cian	23b. Was deceden	months?	1 ☐Live bir	rth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pregnand Other (specify)	у			Date of delive Month	Day Year
S	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□Unknov			((((((((((((((((((
y Pa	Part II. Other signit	ficant conditions co	ontributing to dea	ath but not resi	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?
Completed by								1 □ Y	es 2□No	3 ☐ Prob	oably 4 🛣 Unknown
Sete								24a. Was a	n 24	b. Were auto	psy findings available
E					-			autops perfor	med?	prior to cor death?	mpletion of cause of
De C	25. Was case refer	red to medical					26. Place of Dea	1 Yes ath (Check only or	2 💢 No e)	1 ∐ Yes	2□ No
0	examiner? 1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ In	patient 2 🔀	ER/Outpatier	nt 3 DOA Ot	ner: 4 D Nursing H	Home 5□ Reside	ence 6 □0	Other (Specifi	v)
ü	27. Manner of Deat	th 5 Pending	28a. Date of	f Injury o, <i>Day Year</i>)	28b. Time of Injury	f 28c. Inju Wo		28d. Describe h			
ä	2 Accident	investigation	·			M 1	Yes 2 ☐ No				
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place o buildin	of injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S. City or Tow.	treet and Nu n, State)	mber or Rura	al Route Number,
Medical Certification:		100000									
Ica	29a. Certifier (Check only one)	1 ☐ Certifying Phy 2 ☐ Medical Exam	iner: On the bas	sis of examina	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the c surred at the time, o	ause(s) and late and plac	manner as st ce, and due to	ated. the cause(s)
Мес	29b. Signature and	title of certifier	and manne	ei Statett.		29c. Licen	se number	2	9d. Date sig	ned (Month, i	Dav. Year)
	161	4 - /	1	11-1							
	30 Name and add	ress of person who d	completed sauce	of death (Item	MD (Type	D56	991		MARCH	1, 200	J9
	GHOUSIA		12107 H			,	SILVER S	SPRING, M	ח פר	906	
е	31. Date filed (Mon	nth, Day, Year)					DID VIII L	, I I I I I I I I I I I I I I I I I I I	201	, 50	
r	MAR	0 4 2009	Cenery	B. 1	garlo						

Stat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician March 1858 DVIR 2009 a 01 /Medical 4a. Facility Name (If not institution, give street and number) ity, Town, or Location of Death Peath **Examiner** Ka andallstown Vorthwest Hospita TIMOVE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday)
72 Yrs. 5. Social Security Number **Funeral** Min. **216-34-450**Usual Residence of Decedent 1 □ M 2 🔽 F Months Days Hours Director 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evernher must be notified at 10a. State 10b. County 1 Yes 2 □ No Director timore 10g. Citizen of What Country? 10e. Street and Number USA Completed by Funeral be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Blac 3 承Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Be eeman Pages 1 and 2 should Hanover, MD 2 1076 Department of Health a Important: If item 27 is any injury or other trau once. son 20b. Place of Disposition cemetery, crematic 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral 23a. Part 1. Enter the diseas shock, or heart faile. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ardiovascular Disease Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence offi Examiner Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and sitely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 □ No 1 ☐ Yes 2 **Z**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier TECETITY Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert March 01, 200 Name and address of person who completed cause of death (Item 23a) (Type, Prior 31. Date filed (Month, Day State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Mar. 1, 2009 2030 Physician Jacoby Lee Carol /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Hours Days 146-36-6650 1 □ M 2 🖾 F 62 Months 6,1946 May Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10b. County Montgomery r than "natural", or items 23a or 28a-f show the McJical Examiner must be notified at Montgomery Village 1 Yes 2 □ No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20886 19545 Brassie Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Marriot Hotel Dietician 4 ulth and Mental Hygid 27 is marked other r traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth any lijury or other traumatic event once. Be Mildred Stewart Arthur C.Jacoby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
278 North Ridgewood Ave.Ormond Beach
32!74 19a. Informant's Name/Relationship (Type. Print) Florida Arthur C.Jacoby/Brother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a. Method of Disposition cometery, crematory or other place)
Chesapeake Crem. 3/04/2009 Beltsville, Md. 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PHATER ADDESS TO ALDI FUNERAL SERVICE, P.A. 21. Signature of Funeral Service Licenses 9241 Columbia Blvd.Silver Spring,Md.2091 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracerebral hemmorhage **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☒No 5 ☐ Other (specify) signed by the s Ö 9 Unknown 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ρ The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 1 ∐ Yes Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s after death.

I Director: Aft
d in by the fur 1 ☐ Yes 2 🗌 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064502 completed cause of death (Item 23a) (Type, Print) D 30. Name and address of person who 9901 Medical Center Dr. Rockville, Md 20850 MD Carpenter Brian 32. Registrar's State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 12:30 AM Marie 0. 28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BalTiMORE MD 600d SAMARITAN MOSD, TAK 8. Date of Birth (Month, Day, Year) April 12,1936 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Min. 21932667 1 □ M 2 🗹 F Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Overlea 1X Yes 2 No ed other than "natural", or Items 23a or 28a-f shevent, the Modeal Evanciar court be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A. 3802 Chesley Avenue Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Item ury or other traumatic event, the Medical Exertinal 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No ۾ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Health Care Elementary/Secondary (0-12) College (1-4or 5+) Medical Receptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Teresa Juliano John Robert Mulvaney ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3802 Chesley Ave. Overlea, MD 21206 Charles Jeffries/ Husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a Method of Disposition Evang Fuffer a 1 of Charles permit. Page:
Department o
Important: If any Injury or
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, MD Bel Air 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 /art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorryagic **Physician** STROKE resulting in death) /Medical Due to (or as a consequence of): Examiner gans pens Sequentially list conditions, if any, leading to min solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 □Yes 2 🗹 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has d in by the funeral director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Resono umber, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lock Raven Blud, Bactimore, MD, 21239 5601 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State of Maryland / Department of Health and I 1 - State Registrar Certificate of Death	wentai m	ygien Reg. N	2009	06631
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of D Month	D.	ay Year	3. Time of Death
	/Medic	al	Napoleon Julius Johnson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	March		2009 c. County of Deatl	9:05 P M
	Examin	er	Crescent City Center Riverdale	1	1	rince Ge	_
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of B			hplace (State or Foreign untry)
	Director		230-60-7968 61 Yrs. 61	Apr.			rginia
bud	MC T		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Many	a-f sh	tor	MD Prince George's Hyattsville				1 ⊠Yes 2 □ No
t ot	or 28s	Director	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Co	untry?
oth wi	23a	ral	7612 Swan Terrace 20785			JSA	
r o	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	ipecify Yes or N o Rican, etc.)	10-	14. Race - Ame Black, White	
	io,"	by F	1 □ Never Married 2 ⅓ Married 1 □ Yes 2 ⅓ No If Yes , Give 1 □ Yes 2 ⅙ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates:			Specify: BI	lack
	I amount a should be international and the shall will the waryand item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	sted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	kina	16b.	Kind of Business/l	Industry
V id	han "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	<i></i> 9	Ca	offoldin	
א ליינו	Hygie ther t		12 warenouse Manager 17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's Name	ne (First, Middl			ng Company
g 46	ked o	To Be		ie Burr		,	
shoul	s mar umat	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Re			or Town, State, 2	Zip Code)
M C pue	ealth an 27 is		Marion A. Bishop Johnson-Wife 7612 Swan Terrace, Hy				
ָבָּ בַּ	nent of H ant: If iter ary or oth		20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory of other place) 10 Disposition 10 Dispo	Date	20c. I	Location - City or	Town, State
60	Department Important: I any Injury o					neral, V	
Dail	Department of Department of Important: If it any Injury or once.	,	21. Signature of Funeral Service License 22. Name and Address of Facility The Service, Inc., 117				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			EGUIDU,	Approximate Interval Between
- P	hysician		Immediate Cause (Final disease or condition In The Line Clevet Cardiavaxila	DU	ease		Onset and Death
	/Medical xaminer		resulting in death) Due to (or es a consequence of):				1
	Au	ē	Sequentially list conditions, b. Due to (or as a consequence of).				
patra	d	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause).				
, de	an an irial-tr	Еха	resulting in death) Last Due to (or as a consequence of):				
oor oo, tificate be executed	ng physician and as the burial-transit	edical	d				
Certific	ding p		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	ivory
die di	attending of for use a	sician/N	was decement pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Vac 2 ☐ No. 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
9	by the	Phys	9 ☐ Unknown				
res th	been signed by the	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Die Selen Me Ni tvs: Celrebral In Fan tron		1		the cause of death? obably 4 🗌 Unknown
	peen s	eted		_			
Ne law	a has ge 2 s	Completed	Cornery arten Disease Congestive Rais	per	opsy formed2	prior to death?	topsy findings available completion of cause of
ומו	tificate or, pa	d)	Was ase referred to medica 26. Place of Det		2 2 1 (one)	√o 1 □Yes	2 □ No
Valc	nis cer direct	0 8	examiner?			6 ☐ Other (Spe	cify)
	After thuneral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	e how inj	ury occurred	
Die of	death	icati	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be determined a could not be determined.	28f Location	(Street	and Number or Pi	ıral Route Number,
2 2	after Direct	Certification: To	4 Homicide determined building, etc. (Specify)	City or To	own, Sta	ate)	na Houte Warner,
DIVISION OF VICE RECOIDES, F. C. BOX.	within 24 hours after death, To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Medical C	29a. Certifier 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
P P	withir To th comp	Me	29b. Signature and title of certifier 29c, License number		29d. D	Date signed (Monti	h, Day, Year)
			Andlewellise and DOISS.	2	MA	RCH 2 7	2009
	7		296. Signature and title of certifier Annellow Letter Und DOISS. 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1401 9. 15 VORE WWW 4703 QUEEN Stury Rd Had	attsvi	1/e	MID 20	781
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the Hospitel

Physician

/Medical

10a. State

MD

Examiner

Funeral

Director

23e or 28a-f ehow

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Completed by

Be

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permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than *naturel', or tieme 23e or 28e-f ehov any Injury or other traumatic event, tra Medical Exarchinal must be notified at once.

Baltimore, Maryland 21215-0036

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. # tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and the burial-transit by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed director, Be 25. Was case referred to medical 2 1 ☐ Yes 2 No 27. Manner of Death Certification: After 1 ☐ Maturat 2 ☐ Accident death. within 24 hours after death To the Funerel Director: completely filled in by the 3 Suicide 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kann Willer D4768 3 3/3/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kay mora Miller Rentesions non Strut MD 2113 31. Date filed (Month, Day, Year) MAR 0 4 2009 32. Registrar Signatu State

Registrar

			For State Registrar	State	of Marylan	-	artment of F rtificate of I			ental Hy	giene Reg. No.	2000	06	633
	Physicia /Medic		1. Decedent's Name (First, M		e Theres	sa Knig	ght			2. Date of De Month Februa	Day	Year 2009	3. Time 4:00	
14. 2	Examin		4a. Facility Nam <i>e (If not insti</i> 1250 Forest		•		1	imor	of Death e		4c.	County of Deat		
ì	Funeral Director		5. Social Security Number 214 18 7645	6. Sex 1 ☐ M 2 X F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da 12/19	ay, Year)	9. Birt Co Mai	hplace (State untry) yland	or Foreign
	Maryland -f show	tor	Usual Residence of Deceder 10a. State 10b. Co Maryland			ty, Town or Lo Baltimo							10d. Inside	City Limits
	with the 3a or 28a	Il Directo	10e. Street and Number	Hill Aven	16		10f. Zip Code	1230				zen of What Co	untry?	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemiter must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □	12. Was Dec Armed F 1	cedent Ever in U. forces? 2X No	- 1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No			cify Yes or No Rican, etc.)		14. Race - Ame Black, White	, etc.	
00-01:	in 72 hours n "natural",	Completed by	(Specify only h	edent's Education lighest grade completed	Dates:	16a. Dece (Give life. I	dent's Usual Occup kind of work done o DO NOT use retired	ation during mod	st of workin	g	16b. Kii	nd of Business/	nite	
7 7 0	e filed with al Hygiene other tha vent, the	Be Com	Elementary/Secondary (0- 12th 17. Father's Name (First, Mic	ddle, Last)	(1-4or 5+)		emaker	18. Moth	ner's Name	(First, Middle	, Maiden	Own Ho	ome	
al y a	2 should be and Menta is marked aumatic e	To E	19a. informant's Name/Rela	tionship (Type. Print)	n Jennin	19b. Mailir	ng Address (Street		ber or Rural	Roberta Thompson Route Number, City or Town, State, Zip Code)				
ב מ	ges 1 and 3 t of Health If item 27 or other tr		Marylou Knig 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crema:		20b. F		Forest Hi esition (Name of matory or other place	ce)	Da	ate	20c. Lo	e, Mary	Town, State	
משונו	permit. Pa Departmen Important: any injury once.		4 Donation 5 Doth	er (Specify)		1 22	lge Mem. 1	ss of Facil	lity Gonc		ral		, P.A.	
		(1 (5)	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final	se, or complications that List only one cause on	caused the deat each line.		1	ng, such a	s cardiac or			e, Mary	Approxima Interval Be Opset and	ate etween i Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to	(or as a consequence)	and the same of	IN FARC	7101 Di	seas	e.			104	ears
0,00,0	icate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		a consequence of): a consequence of):					_			
O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Too yes outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) yes Other									23d. Date of delivery Month Day Yea		
. CDI	quires that in signed by	by	Part II. Other significant con	1 . 1	death but not res	ulting in the u	nderlying cause giv		l.		obacco u Yes 2[se contribute to	the cause of	
משט וו	The law recate has bee	Completed	CEREBROUF MULTI-EN	EARLT de	MSUFF	ia Ch	11.	DAN		24a. Was auto perfo	psy ormed?_	death?	topsy finding completion of	s available cause of
חו אוומ	Physician: r this certific ral director,	To Be	25. Was case referred to me examiner? 1 Yes 2 No 27. Manger of Death	Hospital: 1	Inpatient 2	ER/Outpatier		26. Plac er: 4 □ N	e of Death	(Check only	one) dence (6 ☐ Other (Spe	cify)	
	or Attending after death. Director: Afte in by the fune	Certification:	1 Natural 5 □ Pe 2 □ Accident in 3 □ Suicide 6 □ Co	ending (Mo vestigation	nth, Day, Year)	Injury	Worl	k? Yes 2⊡	□No		Street an	d Number or Ru	ral Route Nu	m <i>ber</i> ,
	e Hospital 24 hours e Funeral letely filled	Medical Co	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Physician: To the dical Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the tile evestigation, in my c	me, date a	and place, a eath occurre	and due to the	cause(s)) and manner as I place, and due	stated. to the cause	(s)
h	To the within To the comp	Me	29b. Signature and title of ce		rending	7 Physic	29c. Licens		200			re signed (Mont)		9
_	7		112	MACHIRA				Cho	rice.	40.50	ATO	nsulle	mo	21228
	Sta Registr		31. Date filed (Month, Day,		Registrar's Signa	ature	, ,							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 9 Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 6:36 March 1, Henry W. Klemkowski, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City 1040 Deer Ridge Drive Unit 204 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month) Days | Hours | Min. | Apr. 17, 1952 | Mary land 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1**X**] M 2□ F 56 215-68-2836 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Pedical Examination must be to difficultation. 1XXVes 2 □ No Director Md. N/A Baltimore City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21210 USA 1040 Deer Ridge Drive Unit 204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖔 No 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Yes. Give Specify: à White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r. Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman - ILA Checker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is 1 and 2 should be of Health and Ments item 27 is marked Klemkowski, Sr. Regina J. Drost W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2331 Old Court Rd. #102 Baltimore, Maryland 21208 Henry W. Klemkowski, Sr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or ott 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Hilltop Service Corp. 3/4/09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses mel 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final scandal one hour **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Alatural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

e Hospital or Attending Physician: The law requires that the death certificate be executed a 24 hours after death.

24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the huriah-transit Division of Vital Records, P.O. Box 68760, within 24 hor To the Fune completely fi

Baltimore, Maryland 21215-0036

State Registrar

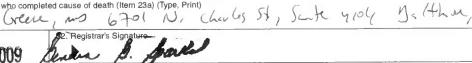
31. Date filed (Month, Day, Year)

M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and the of certifier

29a. Certifier



15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

n 37016

29d. Date signed (Month, Day, Year)

		-	For State Registrar	State of Maryland / I	Department of Health are Certificate of Death		ene 009 06635
ı	Physicia	an	1. Decedent's Name (First, Middle, Last	1.01.190		2. Date of Death Month	Day Year, OO A M
	/Medic Examin	al -	4a. Facility Name (If not institution, give	street and number)	4b-9ity, Town, or Location of	3.	4c. County of Death
	LAdimin		Juture Care	Homework	Baltima		NA
	Funeral Director		5. Social Security Number 6. Se	X Age (In yrs. last bi	Yrs. Honder 1 Year If Under 2 Hours Yrs.	Min. 8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country) MD
	pu 🛦		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	yn or Location	1/11/	10d. Inside City Limits
	ith the Marylar or 28a-f ehow	for	MD N/A		imore		1 (Yes 2 □ No
	or 28a	by Funeral Director	10e. Street and Number	Daxe	10f. Zip Code	10	g. Citizen of What Country?
	ath will	raiD	307 E. 28th St		21218		USA
	items	nue	11. Marital Status 1 □ Never Married 2√ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Meahal Hygiene. If the all is a Marked other then, "naturelt, or items 23a or 28a-f ehow other traumetic event, it is Marieal Examination and infect at	I by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 【 No Specify:		Specify: Black
5-0	"natur	Completed	15. Decedent's Ed (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during most of life, DO NOT use retired)	of working	6b. Kind of Business/Industry Unk
212	withir	omp	Elementary/Secondary (0-12)	College (1-4or 5+) N/A	Landscaper		
	2 should be filed within and Mental Hyglene. Ie marked other then aumetic event, Ins M.	Bec	17. Father's Name (First, Middle, Last) James Lewis, S	2.7	18. Mother	s Name (First, Middle, Ma	
Maryland	should but and Ment and Ment	P			b. Mailing Address (Street and Number		
Mai	and 2 sh salth and n 27 ie n		19a. Informant's Name/Relationship (T Carolyn McNeil)		307 E. 28th Str		o. MD 21218
Je,	of Health of Health item 27 i		20a. Method of Disposition	20b. Place of	of Disposition (Name of ery, crematory or other place)	Date 2	0c. Location - City or Town, State
Baltimore	Pages ment of I ent: If it		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	King		3-7-2009 R	andallstown, MD
Ball	permit. Pages Department of Importent: If is any injury or once.		21. Signature of un- al Service Licen:	see	22. Name and Address of Facility	March E	
			23a. Part1. Enter the disease, or comp	lications that caused the death. Do			Balto,MD 21202 Approximate Approximate
	Pnysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.	Lung Cancer		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	of):		
301	cuted od ransit	Examiner	Cause (Disease or injury that initiated events	C			
8760,	certificate be executed adding physician and use as the burial-transit		resulting in death) Last	Due to (or as a consequence	of);		
687	cate by physic s the b	edical		d			
Box (n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3 Ectopic pregnancy		23d. Date of delivery
	0 0 0	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month Day Year
P.0	requires that the een signed by th nould be detache	/ Phy	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
of Vital Records,	quires in sign uld be	d ba				1 🗆 Yes	3 □ No 3 □ Probably 4 ☑ Unknown
900	as as ca	Completed				24a. Was an autopsy	prior to completion of cause of
E B	The ate h page	Com				perform	ed? death?
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Othor	of Death (Check only one	
10		H	27. Manper of Death		Time of 28c. Injury at Work?	sing Home 5 Resider 28d. Describe how	
sion	Attending r death.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 N		
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, to building, etc. (Specify)	farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
\int_{0}^{∞}	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical C	(Check only 2 Medical Exam	iner: On the basis of examination a	ge, death occurred at the time, date and and/or investigation, in my opinion, death		
	o the l	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29	d. Date signed (Month, Day, Year)
	F S F ŏ		DEGI	luja	D1753	37	3.3.09
	5		30. Name and address of person who	completed cause of death (Item 23a A L U/A 1600 W.	29c. License number D1753 (Type, Print) MOUNT Royal Ave	Bullimore	MD 21217
	Sta Regist		31. Date filed (Month, Day, Year) NAR Ó 4 20	32. Figistrar's Signature	back		

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amend item 29a per dvr 889 3-4-09 vt
State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAKCH **Physician** 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, | 3 9. Birthplace (State or Foreign Country) ecurity Number (In yrs. last birthday) **Funeral** 1 □ M 2 🗷 F OF Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene "instural", or Items 23a or 28a-f show Important; if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once. 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces 1 \(\text{Yes} \) 2 \(\text{N} \) No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Guban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by 3 M Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within College (1-4or 5+) Elementary/Secondary (0-12) Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of cemetery crematory or other) 20a. Method of Disposition Pages 1 3145 1 M Burial 2 ☐ Cremation 3 Removal from State MOKE LAND MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Levestra **Physician** 0 disease or condition resulting in death) * /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 Probably 4 Unknown 2 No 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 🗆 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Vo the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Matural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 🗌 No after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a 29a. Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) her ress of person who completed cause of death (Item 23a) (Type, Print) 8832 BATTO-MD PREI WALTHER 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland / De	epartment of Health and N Dertificate of Death		ene g. No. 2009	06637			
-	Physic /Medi		1. Decedent's Name (First, Middle, La Nelda Edith Lee	st)		2. Date of Death Marth 3		3. Time of Death 4:45 A			
	Exami		4a. Facility Name (If not institution, giv North Hampton Mano	street and number) Y	4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick				
	Funeral Director		5. Social Security Number 6. S 216-22-7592	ex XX 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs. Minnths Days Hours Min.	8. Date of Birth Month, Day May 20	9. Birthp	alace (State or Foreign htry)			
	death with the Maryland ms 23a or 28a-f show r must be notified at	ctor	10a. State MD 10b. County Frederic	k 10c. City, Town o	or Location Y			0d. Inside City Limits 1 ☐ Yes 2€No			
	th with the 23a or 21 sst be no	Funeral Director	13860 Old Annapol	is Rd.	10f. Zip Code 21771	U	10g. Citizen of What Country? United States				
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes AM No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	Black, White,	R1ack			
215-(hin 72 h s. in "natu Medical	Completed by	15. Decedent's Ed (Specify only highest gra	College (1.4er 5.)	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing	6b. Kind of Business/Inc	•			
d 21	filed with Hygiene ther than	Com	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	C00		e (First, Middle, M.	Wagner's Co	rner			
Maryland 21215-0036	ould be Mental arked o	To Be	Basil Dorsey		Mandela (Costley	aiden Surname)				
	ind 2 sh alth and 27 Is m		19a. Informant's Name/Relationship (Patricia Dorsey(D	ype. Print) aughter) 195 M	Hailing Address (Street and Number of Rui 3 Salem Bottom Rd.	Westmins	City or Town MD tat 2 Tig	69°)			
Baltimore,	t. Pages 1 a tment of Her tant: If item jury or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Fairview	Cemetery 3/9/2	2009 T	0c. Location - City or To aylorsvillε	e, MD			
Bal	permii Depar Impor any ir		21. Signature of Funeral Sex ce loer	11.00	Burrier - Queen Funer 1212 W. Old Liberty	al Home	and Cremato	ory, P.A.			
	Physician /Medical Examiner	J.	Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac Heat Pailwe		st,	Approximate Interval Between Onset and Death			
68760, M	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
P,O. Box (that the death certil ned by the attending detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ho 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year			
Records, P	w requires that been signed to should be deta	ò	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	e cause of death?			
Vital Rec	The law ate has b bage 2 sl	Completed	25. Was once referred to medical			-	prior to con death? No 1 □ Yes	osy findings available inpletion of cause of 2 No			
or Vil	thysicia this cert	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No.	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat		n <i>(Check only one)</i> me 5 □ Residen	ce 6 □Other (Specify)			
Division (To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	27. Manner of Deal 1 Natural 2 Accident 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Time Injury 28e. Place of Injury - At home, farm,	e of 28c. Injury at ry Work? M 1 Yes 2 No	28d. Describe how					
Δ	urs after eral Dire		4Torniolde	building, etc. (Specify)		City or Town,	State)				
	the Hos in 24 ho he Fune pletely f	edical		/sician: To the best of my knowledge, de liner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as sta e and place, and due to	ated. the cause(s)			
N.	vith To 1	Z	29b. Signature and title of certifier		29c. License number		B. Date signed (Month, I	Day, Year)			
	6			ompleted cause of death (Item 23a) (Typ		un 117	7 3 1 0 7				
	Sta	te	31. Date filed (Month, Day, Year)	RVM, 196 TJ DLI 32 Registrar's Signature	VE, THEVELCE,	11) 6/1	92				
	Registr	ar	WAR A 4 9000	1. h	all						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06638 Reg. No. 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last)
John E. Lemmon, Sr. 2. Date of Death 2009 Physician 01:23 March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Co. Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) 19 2 3 Mary Land 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 11 M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 219-14-1348 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Maryland 1 Yes 2 No Harford County Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21014 801 Coconut Court Apt. D Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Distribution Engineer N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Astor William F. Lemmon Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Delray Drive, Forest Hill, Maryland 21050 19a. Informant's Name/Relationship (Type. Print) 900 Delray Drive, Forest Hill, Mrs. Mary Gerst (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition March 5,2009 Baltimore, Maryland Most Holy Recemen Cent. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Charcel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee from A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Resp Aculo /Medical Due to (or as a consequence of): (week **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending hysician and or use as the burial-tran Due to (or as a consequence of Accident Physician/Medical Cere mo Vascular 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Emphysema Completed Enfection 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an much autopsy performed? 1□ Yes 2 No 2 🗆 No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director; After this certifical completely filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death Injury Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 6876(Lemman

the Maryland

Baltimore, Maryland 21215-0036

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of pers in who completed cause of death (item 23a) (Type, Print)

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: At the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Harford Rd. Fallston, MC

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item 1 per doc 8889 3-4-09 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Willie Lovett Month Day 200g 15: 45 M **Physician** 27 ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In vrs. last birthday 5. Social Security Number **Funeral X** M 2 □ F Days 07 MD 57 **Director** 216-58-3483 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show at 1 X Yes 2 No Baltimore n 28a-f sl notified Director NA MD 10g, Citizen of What Country? 10f. Zip-Code 10e, Street and Number ö must be 23a 21229 U.S.A. 609 North Chapelgate Lane Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other them? any Injury or other traumed. 'natural", or items dical Examiner mu 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cab Company 12th grade lyr Cab Drive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lessie Willie Lovett Sr. ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7103 Deerfield Road, Pikesville, Md 21208 Akilah Lovett-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 3/3/09 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, suck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final **Physician** Due to or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □ No 1 TYes 1 Tyes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🖊 Inpatient မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 RE S 27/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRASTIANOS PRISCILLA 600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

MAR O

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State of Maryland / Department of Health and Mental Hy	giene 🛚	0	9
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		-	For State Registrar		State of Ma	aryland /		artment of H rtificate of I				g. No.) 9	npp.		
	Physicia		1. Decedent's Name	(First, Middle, Las	it)					-	2. Date of Death Month	Day	Year	3. Time of I		
	/Medic		Richard S. Lykes								February			8:20	A ^M	
	Examin	ęr	and the state of t						U U				4c. County of Death			
			Fairland Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)					Silver Spring If Under 1 Year If Under 24 Hrs. 8 Date of Bi			8. Date of Birth	irth (20) (State or Foreign (20) (State or Fo				
ı	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "netural", or Items 23a or 28a-f show event, If a Maryland Experience out to be notified at the maryland and	Funeral Director	466-52-4176 128 M 2 F 71 Yrs. Months Days Hours Min. Feb.						(Month, Day,	22, 1938 Country) Texas						
altimore, Maryland 21215-0036			Usual Residence of 10a. State		10c. City, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 🛣 No						
			Virginia	nock	ck Flint Hill				10	a Citizan a	f What Cour					
	with th	吉	10e. Street and Num		Lana			22627				•	T TTIAL COU	iti y :		
	eath v	era	11. Marital Status	Hermosa	12. Was Decedent I	Ever in U.S.	13.			rigin? (Spe	cify Yes or No-	USA 14. R:	ace - Americ	an Indian,		
	irs after d	To Be Completed by Fun	1 Never Marrie		Armed Forces?	1 ☐ Yes 2 🗷 No If Yes, Give 1		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			Rićan, etc.)	Black, White, etc. Specify: White				
	2 hou atura		10	ducation	16a. Decedent's Usual Occupation						16b. Kind of Business/Industry					
	thin 7		Elementary/Secondary (0-12) College (1-4or 5+)					kind of work done during most of working DO NOT use retired)								
	ed will							journalis		(F) 1 1 (1) 1 (1)	Newspaper					
	be file tal Hy d oth		17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle								
	ould Men varke varke		Roy B. L				OF 14-10	ng Address (Street			a Ruth S		m State 7in	Codel		
	12 sh 12 and 7 is m maum		19a. Informant's Na					Woodside								
	1 and Healtl		20a. Method of Disp	ykes, Bro	otner	20b. Place	of Dispo	osition (Name of		V. 10			n - City or To			
	permit. Pages 1 and 2 should be filed within Department of health and Mental Hygiene Important: If itam 27 is marked other than any injury or other traumatic evant, If a Magnes.		1 🗆 Burial 2 2 4 🗆 Donation	Cremation 3 5 Other (Specif		Funer	alıç			3/2/				Virgin		
Ball			21. Six atul of Funeral Service Licensee 22. Name and Address of Facility Funeral Choices of Chantilly M00968 14522L Lee Road, Chantilly, Virginia 20151													
	/Medical Examiner burial-transit sthe burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											ween		
			Immediate Cause (disease or condition		a Lymph	noma								1 Yr		
			resulting in death)	(Due to (or as		ce of):									
		L.	Sequentially list cor	nditions,	b. — Due to /or as	Due to (or as a consequence of):										
		lhe	Sequentially list cor if any, leading to im cause. Enter Under Cause (Discase or	rlying	Due to (or as	to (or as a consequence or).										
br		Examiner	that initiated events resulting in death) L	c Due to (or as	as a consequence of):											
68760,-		al E			d											
687		edical			_ 0											
Box	leath certifii attending (I for use as	N/M	IF FEMALE: 23b. Was decedent	23C. If yes, out				come of pregnancy						23d. Date of delivery		
ă	death certi e attending ed for use a	icia	in the past 12 months? 4 Pregnant at time of death 5 Other						opic pregnancy her (specify)			Month Day Year				
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	law requires that the as been signed by th 2 should be detache		Tarrit. Out of significant contributing to country at the thought of the significant contributing to country at the significant contribution of the significan										use contribute to the cause of death?			
ğ	w require been signal		Respiratory Failure								s 2∐No	2 No 3 Probably 4 X Unknown				
Vital Records,	ne law re has be je 2 sh	Completed	Urinary Tract Infection 24a. Was an autopsy								/					
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ita	Hospital or Attanding Physician: 4 hours after death. Funeral Diractor: After this certifica ely filled in by the funeral director, (Medical Certification; To Be C	25. Was case referred to medical 26. Place of Death (Check only one)													
of V			1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6											fy)		
			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describ 2 Natural 5 Pending (Month, Day Year) 2 Accident investigation 4 1 Yes 2 No								28a. Describe no	s now injury occurred				
Sio			2 Accident 3 Suicide				28f Location (St	on (Street and Number or Rural Route Number,								
Division			4 Homicide	determined	building, et	c. (Specify)										
_			29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
			(Check only 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.								o the cause(s	·) 				
	To the P within 2 To tha I		29b. Signature and title of certifier									19d. Date signed (Month, Day, Year)				
			Bara_					D28656 Fe				eb. 2	b. 27, 2009			
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram Passi, MD 5225 Shady Grove Rd., #208, Rockville, Md. 20850													
4	Sta Regist	ate rar	31. Date filed (Mon	th, Day, Year) R 0 4 2005		rar's Signature	9									
			171 AL	/ 181	7 10 00000	· AT	ALC: NO	ATT AND ADDRESS OF THE PARTY OF								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06641 State of Maryland / Department of Health and Mental Hygien 🖓 🛭 🖠 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** February 2009 0012 William Joseph Lagarde /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 № M 2 🗆 F Months Days Hours Min 87 439-07-6935 March 8, Director 1921 Louisiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages I and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Exp. Inc. 1 ust to rediting a 1 ☐ Yes 2X No Director Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10600 Edwardian Lane 21774 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 X Married 1 □Yes 2 No If Yes, Give Year or Dates: Specify: <u>Ş</u> Specify: 3 ☐ Widowed 4 ☐ Divorced WWIT White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Budget Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Clarke ည William Joseph Lagarde 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen F. Lagarde/Wife 10600 Edwardian Lane, New Market, Maryland 21774 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date March 6, 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. M01546 Damia 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, in dry, locally to infinite list cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence of) Examine The law requires that the death certificate be exeguted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Atrial Fibrillation resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

10

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar

9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 4 2009

Jawad Arshad, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARSHAN

DHMH 17 Rev 1/2001

00067782

FEBURARY 24,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 9889 3-4-09 vt State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar 06642 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month **Physician** Marc :00 A **LACHER** EVELYN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea County of Death Examiner tonsv town timore If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 KF Months 111-03-4900 90 91 01/09/1918 Director NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notifiled at any injury or other traumatic event, the M-dical Examiner must be notifiled at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 X No Director FI_{-} BROWARD DEERFIELD BEACH 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code UPMINSTER K 3015 33442 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baitimore, Maryland 21215-0036 WHITE Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **TEACHER EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J0SEPH **COOPERBLUM** LENA ပ္ HIMMELFARB 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID LACHER / SON 4525 HIDDEN HOLLOW DR., ELLICOTT CITY, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR PARK CEMETERY 03/03/2009 PARAMUS, NJ re of Funeral S 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only pipe of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclero Physician rdiovascu Sisea /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12;months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> 2 No 3 Probably 4 Honknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 1 1 1 2 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 harsing Home 5 Residence 6 Other (Specify) 1 Yes 2 N Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide i 🕂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Maid 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#7&20b, perFH, G892,6/12/09, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** ebruar Son 2009 asce armona /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes NIA HOSPITA Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 M 2 F August 22, 1947 Yrs 61 -62 729-01-6966 Guyana Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 Nes 2 No Kaltimore Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 2120 5005 Yor wood 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Baltimore, Maryland 21215-0036 Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) inance ountant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0150N ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD Norwood Himore esiree 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Woodlawn Cemeters 1 Burial 2 □ Cremation 3 Removal from State 2/09 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Howell Funeral Liberty Ave, 4600 Heights Balto MD 2125 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or expiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) fibrirous 3 week Due to (or as a consequent of): and **Physician** /Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the attending physician and hed for use as the burial-trar burial-trar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably DIGSIG Be Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 12 Yes 2 The leath? ZiYes 2 No 2 No Jan Sor Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manper of Death (Month, Day Year) Injury 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed calls of death (Item 23a) (Type, Print) 900 CAT
32. Registrar's Signature ALTIMO RE ATON UE 31. Date filed (Month, Day, Year) State MAR 0 4 2009 Registrar

ype or Print in Black Indelible III. 2374/09 WS AMEND. TTEM 294 per PHYS. C889 374/09 WS State of Maryland Department of Health and Mental Hygiene 0 0 9 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 26, 2009 **Physician** Anna Elizabeth Meidunas 9:57am [™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 93 Sept. 1915 Lithuania Director 13, 219-30-3824 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "Modical Examinar must be notified at 1 ☐Yes 2 XNo Sykesville MD Carrol1 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21784 525 Klee Mill Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event. Seamstress Sewing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jonas Galinas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 525 Klee Mill Road Sykesville, MD 21784 Mr. John K. Meidunas (Son) altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A. Hava PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) ongestive **Physician** Kars /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of) signed by the attending physician abe detached for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by nertens ion 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requii within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be DOVE HOUSE Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined. 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier 29c. License number D33681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Progress Way Suite 114 Eldersburg MD MD MeEVa 1380

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 mq00:8 March 1 Cornelia Merritt Merwin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carrol1 Sykesville Fairhaven Health Care Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | Mar 13, | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) 1 □ M & □ F 070-12-3244 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 🏋 ☐ No Sykesville MD Carrol1 Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 21784 7200 Third Avenue C-86 within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White If Yes, Give Year or Dates: ģ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home Economist permit. Pages 1 and 2 should be filed beatment of Health and Mental Hygid Important: If Item 27 is marked other any Injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Prudence Olney S. Bert Merritt 19a. Informant's Name/Relationship (Type. Print)

Mrs. Barbara M. Patterson (Daughter) 109 E. Greenbriar Dr. York, PA 17407 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 3/2/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License, HATCHIO FUNERAL HOME & CHAPEL, P.A. H-MO0764 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) leulcemica **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months
1 Yes 2 No
9 Unknown Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy perform 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of eath 28d. Describe how injury occurred After 5 ☐ Pending investigation Natural Accident 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, ours after death.

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To the Funeral I

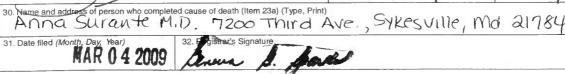
completely filled To the Hospital

Registrar

31. Date filed (Month, Day, Year) State MAR 0 4 2009

29b. Signature and title of certifier

29a. Certifier (Check only one)



11.

29c. License number

DO02602

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma		epartment of I Certificate of		Mental Hy	/giene () Reg. No.	09	06646
	Physic /Medi		1. Decedent's Name <i>(First, Middle, L</i> Virginia Letici		al			2. Date of De Month Februa	Day	009	3. Time of Death 2:30 PM
	Exami		4a. Facility Name (If not institution, g 7954 Quarterfie			4b. City, Town, o Severn	or Location of Death		1	ty of Death Arun	
	Funeral Director		5. Social Security Number 6. 915-77-0689 Usual Residence of Decedent	Sex 7.Age 1□M 2 🖾 F	6 (In yrs. last birti	nday) If Under 1 Year Months Days		8. Date of Bi 03/20/1	rth av, Year) L953	9. Birth Cou Guat	nplace (State or Foreig Intry) Cema1a
	the Maryland 28a-f show	rector	10a. State 10b. County MD Anne Ar 10e. Street and Number	undel	10c. City, Town				10g Citizon		10d. Inside City Limits 1 May Yes 2 □ No
	h with	al Dii	7954 Quarterfie	ld Road		2114	44		10g. Citizen o	emala	*
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland D. partment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Maryland Eas nit or must be refitted at other.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 XYes 2 ☐ No		pecify Yes or No Rican, etc.)		ace - Ameri lack, White, cify: Whi	etc.
21215-0036	d within 72 hu giene. ir than "natu	ompleter	15. Decedent's B (Specify only highest g Elementary/Secondary (0-12)	ducation rade completed) College (1-4or 5	+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire fice Manage	during most of work ad)	sing	16b. Kind of		idustry
Maryland	12 should be filed within 'h and Mental Hygiene. 7 is marked other than "r traumatlc event, Ire I's	To Be C	17. Father's Name (First, Middle, Las Luis Guzman				18. Mother's Nam Unknow	า			
Mai	1 and 2 sh Health an em 27 is n		19a. Informant's Name/Relationship Fernando Mendiz		131	Mailing Address <i>(Street</i> 1 Burlingto	and Number or Rui On Drive,	ral Route Numb Odento	per, City or Tow n , MD	n, State, Zij 21113	
Baltimore,	Pages 1 annent of He		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 [4 □ Donation 5 □ Other (Spec		1	Disposition (Name of c, crematory or other pla cremation Serv	i	Date	20c. Location	-	
Balti	permit. Page D. partment of Important: If any Injury or	ı	21. Signature of Funeral Service Lice		ALCAIC	22. Name and Addre	ess of FacilityArd	ent Cre	mation	servi	ces
100	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lin	e.	ot enter the mode of dyi	ng, such as cardiac	-	-		Approximate Interval Between Onset and Death
60,	cate be executed by physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of				-		
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су	_		Pate of deliver	very Day Year
	uires that n signed b	þ	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying cause giv	en in Part I.	23e. Did 1	we.		the cause of death?
of Vital Records,	sician: The law requir certificate has been s rector, page 2 should	Completed						24a. Was	an 24b psy prmed?	. Were auto	opsy findings available ompletion of cause of
l Vit	Physician: this certific al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	nt 2 □ FR/Outr	patient 3 DOA Oth	26. Place of Deat ner: 4 ☐ Nursing Ho			ther (C	X.)
Division of	ath. rr: After re funer	Certification: T	27. Manner of Death Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not I	28a. Date of Injur (Month, Day	y 28b. Ti (<i>Year</i>) Inj	me of 28c. Injury Wor	ry at k? Yes 2 □ No	28d. Describe	how injury occu	ırred	
Οİ	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		4 ☐ Homicide determined	building, etc	. (Specify)	death occurred at the ti	me date and place	and due to the	wn, State)	mannar ac s	al Route Number,
	To the He within 24 To the Fu	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	miner: On the basis of and manner sta	examination and	29c. Licens	opinion, death occur se number	red at the time,	date and place 29d. Date sign	e, and due to	o the cause(s) Day, Year)
	0 1		30. Name and address of person who	completed cause of de	eath (Item 23a) (T M () 9	ype, Print) OO BESTO	ate Rd.	Anv	apolis	, Ma	9 21401
	Sta Registi		31. Date filed (Month, Day, Year)		*'s Signature	baces			, ,		•
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			For State Registrar	State of Ma		Depa		of Healt	th and M	lental Hy	giene	009	06	64
	Physici		1. Decedent's Name (First, Middle, Las Elizabeth	A.	Me	cQuad	de			2. Date of De Month March	ath	Year	3. Time of 5:30	Death PM
1	/Medic Examin		4a. Facility Name (If not institution, giv Riverview Rehabil			~	4b. City, To	wn, or Locat	ion of Death		4c. Coun	ty of Death		
	Funeral Director		210 21 0332	ex	e (In yrs. last I	<i>birthday)</i> Yrs.	If Under 1 Months	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da March 24	th 19, Year) 1, 1930	9. Birthpl Coun Mary	ace (State o. Land	r Foreigr
re, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Experience result be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon 10e. Street and Number 1000 Franklin Aven 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grave) Elementary/Secondary (0-12) 12 years 17. Father's Name (First, Middle, Last, John Blackhurst 19a. Informant's Name/Relationship (Jack McQuade 20a. Method of Disposition	12. Was Decedent Armed Forces? 1	Ever in U.S. No 16	13. V III 15a. Deced (Give iiife. E Nurs	Nas Deceder f Yes, specify Yes 2 dient's Usual Chind of work OO NOT use	21221 and of Hispania of Cuban, Men Cuban, Men Spe Decupation done during retired) 18. M A Street and No	most of works nt tother's Name nnie E umber or Rur.	e (First, Middle, Buckley al Route Numb	14. R. Bl Spec 16b. Kind of HOSPi Maiden Surna	What Count SA ace - America ack, White, e ack, White, e Business/Ind tal ame)	an Indian, tc. te ustry Code)	
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any Injury or other tr		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif. 21. Signature of Funeral Service Licer	(y)		y Hil	ll Memo	orial Address of F y Fune	200 ral Ho		Middle Oundalk	, P.A.	•	
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Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inju (Month, Da	ent 2 ER/0 ry 28t y, Year)	Outpatien D. Time of Injury		0.11	Nursing Ho	h <i>(Check only c</i> nme 5 ☐ Resi 28d. Describe	dence 6 □C)	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		3 ☐ Suicide 6 ☐ Could not be determined	building, et	c. (Specify)					28f. Location (City or To	wn, State)			ber,
	the Hosp hin 24 ho the Fune	Medical	(Check only 2 Medical Examone)	nysiclan: To the best miner: On the basis of and manner sta	f examination		vestigation, ir	n my opinion	, death occur		date and place	e, and due to	the cause(s)	
D	§ 5 ₹ 5		29b. Signature and title of certifier	M.D			C	icense numb		1	29d. Date sign	103	og, rear)	
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	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 2009	Denota .	a s Signature	par	U							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MillER Month Year **Physician** 17:10 PM 0 HRTELLA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Samaritim Hospital BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours 215-12-3256 Director MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Eventhal format be notified at once. **Funeral Director** 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 V No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced Whit 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JALTIMORE. 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 09 FOREST HILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility/6924 YORKER, Mon Lton MD 21111 Chapel + Cremation SERVICES-Morken 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only/one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

RESPIRATORY FAILURE DUE TO PNEUMO

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Palmonary disense 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an this certificate has autopsy performed? res 2 No 1 □Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 Pending investigation 2 No 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) a7 deus RESOOO 03,02,09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Blyd.

Registrar
DHMH 17 Rev 1/2001

State

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tho	r 28a-	Director	10e. Street and Number					10f. Zip Code	-			10g. C	itizen of Wha	at Count	ry?	
th seift	23a o	al D	33 Haddingto	n Road	E			210	93				U.S	. A .		
1000	tems	Funeral	11. Marital Status	Arm	ed Forces?		3. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Or an, Mexica	rigin? (Spo n, Puerto	ecify Yes or i Rican, etc.)	10-	14. Race - Black,	America White, e		
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			30. Name and address of perso	n who complete	d cause of	death (Item	1 23a) (Tvne	Print)	75	101			une	Tr	1500	
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	or 28	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	/hat Coun	try?
	th wil		3645 Derby Shir	e Circle			244		U.S		
	r dea	Funeral	11. Wantai Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S ເກ, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Black	e - Americ k, White, e	
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	M∏Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify:	Bla	ck
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			23a. Part 1. Enter the disease, or compli	cations that caused the death	n. Do not en	300 Waba ter the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Ma	Approximate Interval Between
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×	certif nding ise as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		_			23d. Dat	te of delive	ery
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'n.	gned gred	by P	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	ınderlying cause giv	en in Part I.			10	ne cause of death?
ğ	equire en si ould t	ed						1 🗆 Y	′es 2 □ No	3 Prob	oably 4 Unknown
မင	law re as be 2 sh	Completed						24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
<u> </u>	The cate h	ပ္ပြ								death? 1 □ Ye s	2 🗆 No
/ita	cian; sertific	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath Check only o	ne)		
of	Physical this call direct all direct the call	은	1 ☐ Yes 2 ☑No	1 ☐ Inpatient 2 ☐	ER/Outpatie		4 🗆 Nursing	Home 5 Resid	dence 6 Oth	er (Specif	muspig
n C	Jing I	io	1 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	Wor	k? Yes 2□No	200. Describe i	low injury occurr	eu	
isi	death death ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, st					er or Rura	al Route Number,
Division of Vital Records,	after after Dire d in b	Certification: T	4 ☐ Homicide determined	building, etc. (Specify	(y)			City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Phy	rsician: To the best of my kno iner: On the basis of examina	wledge, dea	th occurred at the ti	ime, date and place	ce, and due to the	cause(s) and ma	anner as s	stated.
	he Ho in 24 he Fu pletel	Medical	one)	and manner stated.	mon and/of I						
	vithi To ti	Z	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
			Meran	~~>			20207		MONC	nI	0007
0	itl v		30. Name and address of person who c	ompleted cause of death (Iten	6701		arls so	- Tawas	NM)	
		ate	31. Date filed (Month, Day, Year)	32. Jegismar's Signa	iturg	and					
	Regist	tell	MAR U 4 2U	US Come	1. 14						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#8perFH, G889, 3/11/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Lorraine V. Miller 4:40 P. M 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll 1436 Nicodemus Road New Windsor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Pay, Year)
May 20, 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 X F Maryland Director 216 18 3504 1920 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show Health and Mential Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f shov ither traumatic event, I'm Modical Examinac mass be restiffed at 1 ☐Yes 2 X No Director New Windsor Carrol1 Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21776 U.S.A. 1436 Nicodemus Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: \$ Specify: 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William F. English Emma V. Marsh ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other troone. Dorothy Thompson / Daughter 1436 Nicodemus Road New Windsor, Maryland 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park: 03/06/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. nameound 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** Jear disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physlcian: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mg 1 □Yes 2 □N Month 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? certificate has b rector, page 2 sh 24a. Was an autopsy performe 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death. leral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 We certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of

Registrar
DHMH 17 Rev 1/2001

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Hame and address of p

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125 Airport Drive Ste 34

			For State		•	State of Ma	iryiano	-	rtment of F tificate of t		and Me	-	giene Reg. No	00	0.0	0.0	CCE
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	Examin		4a. Facility Name (reet and number)			4b. City, Town, o					County of			
			8209 Boi			7 400	//m . wa fa	at hirthdays)	Baltimor If Under 1 Year		24 Hrs o	Date of Bir	th	Balt			e or Foreign
	Funeral Director		5. Social Security N	1331	6. Sex	M 2 X F 7. Age	79	st birthday) Yrs.	Months Days	Hours	Min. (Date of Bir Month De 08/05/	T929		Mary	y land	Poreign
	land ow		Usual Residence of 10a. State	10b. County			10c. City,	Town or Loc	ation						11	Od. Inside	City Limits
	Mary Fed s	tor	MD	Baltim	ore		Bal	timore	9							1 □ Y	es 2⊠No
	th the	Director	10e. Street and Nu						10f. Zip Code				10g. Cit	izen of Wh	at Coun	try?	
	23a c	ral	8209 Bot	n Air R	oad				21234				U.S	.A.			
30	be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Modical Eventing must be notified at	by Funeral	11. Marital Status 1 □ Never Marr 3 ☒ Widowed			2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba □Yes 2 👿 No	lispanic Origan, Mexican Specify:		ify Yes or No can, etc.))-	14. Race - Black, Specify:	White, e		
2-003p	tural	ed		15. Decedent	's Educa	tion	T	16a. Deced	ent's Usual Occup	ation			16b. K	ind of Busi			
מ	hin 72 e. an "na Medii	Completed	(Spec	cify only highes ondary (0-12)	st grade (completed) College (1-4or 5-	+)		ind of work done O NOT use retired	during most d)	t of working		D = =				
7	filed within Hygiene. other than '	Sol	б				,	Cosme	tologist				Bea				
and		Be	17. Father's Name		Last)							First, Middle	, Maiden	Surname)			
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<u> </u>	2 0 0 0					Daughter			Bon Air							0000)	
ā,	s 1 and of Health item 27 other t		20a. Method of Dis	sposition					sition (Name of latory or other place		Dat			ocation - C		wn, State	
Baltimor	permit. Pages Department of Important: If its any Injury or o			Cremation 5 Other (S)		moval from State			ervice C		03/03	/2009	Tows	son, I	Mary	land	
a	permit. Departn Importa any Inju		21. Signature of Fi	uneral Service	Licensee		1		Name and Addre			onard					
מ	8 8 E 8) Ulax	randria	7	Blan	,	5:	305 Harfo	ord Ro	oad, E	Baltim	ore,	MD 2	1214	4	
	Physician /Medical Examiner		23a. Part1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List (Final on	complication only one	cause on each lin	ic of	bstru	ctive po							Approxin Interval E Onset an	Between
Ų.	ed sit	niner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	inditions, nmediate erlying	Ь.	Due to (or as	a conseque	ence of):									
,	ifficate be executed g physician and as the burial-transit	Examiner	that initiated event resulting in death)	S	c.	Due to (or as	a conseque	ence of):								-	
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Ξ.	ertifica ling ph e as th		IF FEMALE:		T												
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coras	requi	eted			-									_			
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VITAI	iding Physician: th. After this certifica funeral director,	Be o	25. Was case reference examiner? 1 ☐ Yes 2 ☑			spital:	00	ER/Outpatien	Oth	ner.		Check only o		C			
0	g Phy er this eral d	n: To	27. Mann of Dea			28a. Date of Inju	ry	28b. Time of	28c. Inju			e 5 🔀 Resi 3d. Describe				<u>y)</u>	
0	ath. r: Affu e fun	atio	1 Matural 2 Accident	5 ☐ Pendin investig	g gation	(Month, Day	y, Year)	Injury		rk?]Yes 2 🔲	No						
DIVISION	ipital or Attenors after deat ours after deat leral Director: filled in by the	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could in determine		28e. Place of Injubuilding, etc	ury - At hor c. (Specify	ne, farm, stre	eet, factory, office		28	Bf. Location (City or To	Street ar wn, State	nd Number	or Rura	l Route N	lumber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely illed in by the funeral director,	edical C	29a. Certifier (Check only one)			cian: To the best of er: On the basis of and manner sta	f examinati										e(s)
_	Vithir Comp	Me	29b. Signature and	_		A	4	ni .	29c. Licens			4	29d. Da	ite signed (Moπth,	Day, Year	·)
			mu		-	- Atten				D 20	6536	+		2/2	7/0	9	
1	2 1		30. Name and add	Kelow		120 5	ster	Pierre	Print)	#10	T To	wson	, m	11) 2	112	04	
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DHMH 17 Rev 1/2001

			_ For		/ Depa	rtment of H	lealth and	All Copies I Mental Hy		_	
			1 - State Registrar		Cer	tificate of I	Death		Reg. No.	2009	06653
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) FRANK	Mau	REV	ζ		2. Date of De Month FEBRADI	Day	Year 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of De	ath	4c.	County of Deat	h
	Funeral Director		219-40-7963 XX ^M ^{2□} F	ge (In yrs. last		If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bir n. (Month, Da	th ay, <i>Year)</i>		hplace (State or Foreign untry) yland
7	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	cation					10d. Inside City Limits
1	Mary a-f sh	tor	Maryland Baltimore	Dunda	ı1k						1 □ Yes 2 □ No
1	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	untry?
4	ath w		1722 Burnham Rd.		- 1	21222			USA		
30	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Because the more and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I've Medical Evandria in ust be notified at once.	by Funeral	11. Marital Status 1 □ Never Married ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 14. Was Pecedent Armed Forces? 17. Was Decedent Armed Forces? 17. Was Decedent Armed Forces?	No	١,	Mas Decedent of H fYes, specity Cuba i⊡Yes X XXNo	ispanic Origin? an, Mexican, Pui Specify:	(Specify Yes or No erto Rican, etc.))-	14. Race - Ame Black, White Specify: Wh	e, etc.
3-003b	2 hour		15. Decedent's Education		I6a. Deced	dent's Usual Occup			16b. Ki	nd of Business/	Industry
2 2	thin 7; le. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or secondary (1-4or seconda	5+)	(Give life. L	kind of work done o OO NOT use retired	during most of w i)	orking			
N	12 should be filed within 7: h and Mental Hygiene. 7 is marked other than "n traumatic event, Ille Mo		12th	M	fechar	nical Eng		(Final paint)			Society
and	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Frank Louis Mauter					ame (First, Middle A. Bushma		Surname)	
	hould nd Me mark matic	၀	19a, Informant's Name/Relationship (Type, Print)		19h Mailin	ng Address (Street		Rural Route Numb		r Town, State, 2	Zip Code)
2 3	nd 2 salth ar 27 is r trau		Frances C. Maurer Wife			,		alk, Mar			
e,	is 1 au of Hea item othe		20a. Method of Disposition	20b. Place		sition (Name of natory or other place		Date		ocation - City or	Town, State
altimor	Page nent d ant: If		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			L Memoria		3/2009	Mide	dle Riv	er, Maryland
Dall	permit. Departi Imports any Inji		21. Signature of Funeral Service Licensee		Di	122 Wise	Funeral	Home of	arvl:	-	
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. I ine.	Do not ent	er the mode of dyir	ng, such as card	lac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	hysician			EMIC		SWEL					2 00 P
	/Medical Examiner		Due to (or as	a consequen	nce of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequen	nce of):	-					
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oo,	be exe ician ar burial-tı			a consequen	nce of):		-				
08/0	cate b	dica	d								
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown	2 Fetal de	eath 3 🗆	Ectopic pregnanc Other (specify)	у		:	23d. Date of de Month	livery Day Year
7.	w requires that the de been signed by the should be detached i		Part II. Other significant conditions contributing to death t	out not resultir	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
spi	quire; en sig uld be	ed by						_ 1 🗆	Yes 2	□ No 3□ Pi	robably 4 Unknown
Vital Records,	The law re ate has bee bage 2 sho	Completed						24a. Was - auto perfe 1 □ Yes	psy ormed?	prior to death?	utopsy findings available completion of cause of
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OT /	hysic this c		1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpati			nt 3 DOA Oth	4 🗆 Ivursii i	Home 5 Res			cify)
slon	to the hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death after this certificate has completely filled in by the funeral director, page 2 s	Certification: To	27. Manner of Death 1	ay, Year)	Bb. Time of Injury	M 1□	ryat k? Yes 2 □ No	28d. Describe		,	Tauta Number
אוט פֿינ	pital or A rurs after or eral Direc filled in by		determined 200, 1 lace of the	tc. (Specify)		eet, factory, office	me date and al	City or To	wn, State	?) 	ural Route Number,
001	24 ho 24 ho 3 Fun etely	Medical	(Check only 2 Medical Examiner: On the basis one) and manner s	of examination	n and/or in	vestigation, in my	opinion, death o	ocurred at the time	date and	d place, and due	e to the cause(s)
To the	To the within To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Da	te signed (Mont	th, Day, Year)
N.			1 Land			RES	5-00C		FER	sizuary	27,2009
-			30. Name and address of person who completed cause of	death (Item 20	3a) (Type,	Print)					e, MD ZIZZY
5	T1 /		KAISORN CHAICHANA	M·D.	4	940 EA	STERN	AVENUE	Bo	LTINGE	e, MD 21724
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	rars Signature	1	and I					
DHM	1H 17 Rev 1/2		31. Date filed (Month, Day, Year) 32. Begist	a p	19						

Division of Vital Records, P.O. Box 68760,

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	1 - State amend	#10e&f Per	FH G889	3/06/09 Jh Certificate of	Death	R	Neg. No. 200	06654
Physician	1. Decedent's Name (First, Middle					2. Date of Dea Month		3. Time of Death
/Medical	FRANK	MIMEN	TO	# 63 T	- Lander of Dank	2	27 2000	
Examiner	4a. Facility Name (If not institution JOHNS HOPK IN 5. Social Security Number	13 BAYVIE		BALTI		8. Date of Birth	4c. County of Dea	
Funeral Director	216–36–2322 Usual Residence of Decedent	1 X M 2 □ F 71	e (In yrs. last birthe Yr	Months Days	Hours Min.	I (Month Day	(, Year) C	cyland
yland	10a. State 10b. County		10c. City, Town of	or Location				10d. Inside City Limits
after death with the Marylan or items 23a or 28a-f show oricer must be codified at Funeral Director	Maryland N/A		Baltimo	ore				1XOKýes 2 □ No
vith th	1711 Swansea R			10f. Zip Code	21239	1	10g. Citizen of What Co	
sath v	240 S. Exeter S	12. Was Decedent E	Ever in IIS	21202		posify Vos or No.	United Sta	
tter death w	11. Marital Status 1 ☒Never Married 2 ☐ Marr	Armed Forces?	lo	13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Whit	
ral", o	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 23 Year or Dates:		1 □Yes 2MXNo	Specify:		Specify: V	√hite
72 ho	15. Deceden (Specify only highes	t's Education st grade completed)	1 (0	Decedent's Usual Occup Give kind of work done	during most of work	ing	16b. Kind of Business	/Industry
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, tre Marical Examination that be notified at e Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4or 5-		life. DO NOT use retired sabled	1)		N/A	
tal Hyg d other event, l Be C	17. Father's Name (First, Middle,	Last)	1		18. Mother's Nam	e (First, Middle, i	Maiden Surname)	
Menta Menta arked artic e	Rocco Minento				Catheri	ne Palmi	isano	
2 sho h and ris m rraum	19a. Informant's Name/Relations		l l	Mailing Address (Street				
1 and Healt em 2	Rosanna William 20a. Method of Disposition	ns - Niece	20b. Place of D	06 Stiles			Maryland 2 20c. Location - City or	
ages ent of nt: If it y or o	1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		MOST_F	crematory or other place ioly Redeem	er		•	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, it a Invited Expone. To Be Completed by	21. Signature of Funeral Service			metery 22. Name and Addre David J. We	ss of Facility	4/2009 mp.l. Mome	Baltimore,	Maryland
B a m Ce	Jam KJ	<u>/</u>		401 S. Che	ster Stre	et Balti	more. Mary	land 21231
	2. Part 1. Enter the disease, shock, or heart failur . List	Tomplications that caused only one cause on each lin	the death. Do no					Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. ACUTE	200 100 100 100	ARDIAL I	NFARCT	TION		3 HOURS
Examiner			a consequence of)): 				
iner at	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as a	e curisaquence of)	j.				
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nat the death certificate be of by the attending physicis letached for use as the bu Physician/Medical		d						
eath cer attendin for use.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 ☐ Fetal death	3 ☐ Ectopic pregnanc	v		23d. Date of de	
the at hed fo	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ☐ Other (specify) _			Month	Day Year
that the led by detack	Part II. Other significant condition	ons contributing to death bu	ut not resulting in t	he underlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
w requires the been signed should be deferted by			_			1 🔲 Ye	es 2 No 3 P	robably 4 💆 Únknown
g 22 0						24a. Was a		utopsy findings available completion of cause of
						perfori	med? death? 2 No 1 ☐ Yes	_
certifi rector	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
Physer this eral dir	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Na Inpatie		Datietik 3 DOA	4 LI Nursing H		ence 6 Other (Spe	ecify)
Attending For death. ector: After by the funer. ification:	1 Natural 5 ☐ Pendin 2 ☐ Accident investig		<i>i, Year)</i> Inju	ury Worl	k̂? Yes 2 □ No		,	
tal or Attending Physics after death. al Director: After this led in by the funeral director: Certification: To	3 Suicide 6 Could in determined		iry - At home, farm	n, street, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
ours a ours a neral C	29a. Certifier 1 Certifyir	ng Physician: To the best of	of my knowledge,	death occurred at the ti	me, date and place.	and due to the o	cause(s) and manner a	s stated.
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun Medical Certificatio	(Check only 2 Medicel one)	Exeminer: On the basis of and manner sta	examination and/	or investigation, in my o	pinion, death occur	red at the time, d	date and place, and due	e to the cause(s)
To to To To To To To To To To To To To To To	29b. Signature and title of certifie	000		29c. Licens		2	29d. Date signed (Mont	
	20 Name and address of		1.D		000		2. 21.09	
+ /	30. Name and address of person VISHAL MEHRA	, 600 N. W	DLFE ST	, CARNEGII	€ 568, B.	ALTIMO	RE, MOZ	1287
State Registrar	31. Date filed (Month, Day, Year)	32. Registre	R 0 4 200	9 Senone	A. So	ALD.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year **Physician** 02 30 AM Feb 27 William Nickens Sr. 2009 Savington /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Bulhmore ah Balhmore 0 If Under 1 Year If Under 24 Hrs. R. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 1 □**X**4 2 □ F 82 Director 229-28-5132 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number pe or 21211 ed other than "natural", or items 23a event, the Medical Examiner must b 3924 Greenspring Ave U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 □ No Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Virginia Freight Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Truck Driver Line 18, Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Department of Health and Mental I Important: If item 27 is marked oft any Injury or other traumatic ever once. 2 should be finance and Mental h Elza Nickens Eva Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bessie Nickens-Wife 3924 Greenspring Ave, Baltimore, Md 21211 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 3/6/09 Owings Mills, Md n Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Sonatore of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lature. List only one cause on each line.

Imm late Cause (Fina Approximate Interval Between Onset and Death Ven truelar Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ Hupertention 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performe funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 TER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No ٩ this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred After t at or Attending F s after death. Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Deline Fib 27, 2009 050693 un

DHMH 17 Rev 1/2001

State Registrar ALDEN G.

31. Date filed (Month, Day, Year)

91119

SNAI HOSPITHL OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEOPLES, MD

MAR 04 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06656 State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** John Joseph O'Neill, Jr. 8:20p 2009 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll 493 Hawk Ridge Lane Sykesville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 TT 8. Date of Birth (Month, Day, Year) Dec 4 1930 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ∏ M 2 □ F Yrs 050-24-2292 78 Dec 4 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be motified at Sykesville MD Carrol1 1 ☐ Yes 2 🕅 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 21784 USA 493 Hawk Ridge Lane Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ²□No Korea Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ 3 Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) electrical electrical engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Feeney John Joseph O'Neill, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Jacobe (daughter) 467 Hawk Ridge Lane, Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 X Removal from State Long Island National 3-9-09 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Rome & Chapel 21. Signature of Funeral Service Licensee Daig Staight Serbert P.O. Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical o (or a /a consequen / of): onsequency of):
or traphic lateral sekrosis Examiner Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of) Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

reral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifie

Registrar

State

Unres: 4 Baltimar, MD =1287

npleted cause of death (Item 23a) (Type, Print)

6hrs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 06657 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye ar **Physician** 7:48PM Odusanya Α. Johana tepruary 24,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death નેc. County of Death Examiner 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Days Hours Director 410-95-6751 28 80 England 28 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatih and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 2.0 or 28a-f show ury or other traumatic event, I'm. Marcial Ex. vint. ... until extending a 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 X No Director Owings Mills MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 England 225 Gentle Brook Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 ∏Yes 2**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 ☐ No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary_(0-12) College (1-4or 5+) Sales Person Private 12th grade 3yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Folashade Shodeyl Charles O Odusanya 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Gentle Brook Road, Owings Mills, Md Funmi Fadina-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department o Important: If any injury or once. Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 3/6/09 Woodlawn, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West 21. Signatura of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final **Physician** days SEDSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DWS Sequentially list conditions, if any, leading to immediate cause. Explored the cause (Disease or injury that initiated events resulting in death) Last Due to (or as A consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an s certificate has to irector, page 2 sl 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this eral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) HPBroary Zb 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

VE BALTIMORE MO 2/229

State of Maryland / Department of Health and Mental Hygien

		•	for State Registrar		,	Cer	tificate of l	Death		Re	g. No.		
	Physici /Medio		1. Decedent's Name (First, Middle, Last	LL						Date of Death Month	Day 28	Year 09	3. Time of Death 740 Pm M
	Examir	er	4a. Facility Name (If not institution, give Good Samaritan		Center		4b. City, Town, or Baltimo	re			4c. County	of Death N/A	
	Funeral Director		219-01-3170	7. Age	(In yrs. last i	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. M	Date of Birth (Month Day, ay 02,	1920		place (State or Foreign of Tand
	e Maryland	Director	Usuel Residence of Oecedent 10a. State 10b. County Md. Baltimor	e	10c. City, To Essex	own or Lo							0d. Inside City Limits 1 ☐ Yes 2X No
	h with th		10e. Street and Number 1626 Sandy Hollo	w Circle			10f. Zip Code 21221			10	g. Citizen of		ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow important: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Ximidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Orig n, Mexican Specify:	jin? (Speci , Puerto Ri	y Yes or No- can, etc.)		ck, White,	ean Indian, etc. ite
15-0	in 72 ho n "natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)		Sa. Oeceo (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most	of working	1	6b. Kind of B		dustry
1212	ted with tygiene. her that		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5-	+) H	omema	aker	19 Mothe	r's Name (First, Middle, M	Own Ho		
lanc	uld be fi Mental H irked ot itic ever	To Be	John J. Dengler						L. C		alderi Stirial		
, Mary	and 2 sho balth and h n 27 is ma er trauma		19a. Informant's Name/Relationship (7 Mary R. Erb/ Daugh				ng Address <i>(Street a</i> Sandy Ho						
Baltimore, Maryland 21215-0036	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		сете	tery, cren ney	sition (Name of natory or other place Valley Me	m. 3	Dat 5-6-09		Timon		
Balt	Depention Depention Important Import		21. Signature of Funeral Service Licen	"hy		22	Name and Address Ruck Tow 1050 Yor	SON F	unera	1 Home	Inc.	1	
	Physician /Medical Examiner	her	23a. Part1. Enter the disease, or composition shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	Due to for an a	e. 4DV a consequence	A /V se of):	er the mode of dyin	-					Approximate Interval Between Onset and Death
68760,	rtificate be executed ng physicien and s as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	ı consequenc	e of):							
.O. Box 6	The law requires that the death certifics the has been signed by the attending phoage 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1	2 Fetal dea		Ectopic pregnancy Other (specify)					ate of deliver	ery Day Year
Ω.	w requires that is been signed by should be deta	2	Part II. Other significant conditions on High Bloc Almal				nderlying cause giv	en in Part I.			acco use con	tribute to t	he cause of death?
Division of Vital Records,		Completed		Fibrill gnide)ai				24a. Was ar autopsy perform 1 Yes 2	ed?	Were auto prior to co death? 1 \(\text{Yes}	opsy findings available impletion of cause of
Vita	iicien: certific rector,	o Be (25. Was case referred to medical (/ examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 🗆 ER/	Outpotion	nt 3 DOA Oth			Check only one	-	(C	
ion of	Hing After	F	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		D. Time of Injury	28c. Injun Wor		28	d. Oescribe ho			y)
Divis	or after	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At home (Specify)	farm, str	reet, factory, office		28	f. Location (Str City or Town		ber or Run	al Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Example 1	ysician: To the best on niner: On the basis of and manner sta	examination	dge, death and/or in	h occurred at the lin vestigation, in my o	ne, date an pinion, dea	d place, an th occurred	d due to the ca at the time, da	use(s) and m te and place,	anner as s and due t	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and titte of certifier		4 .	41 44	29c. Licens				d. Date signe		-
,				completed cause of de	\sim		1	006	12/	2	3 · 5	2.0	7
H	V		30. Name and address of person who of SAECD UDD/A 31. Date filed (Month, Day, Year)	J CHAN	r's Signatur	(G000	SAI	NAR	ITAN	H	05/5	1
	St: Regist	ate rar	MAR 0 4 2009	Ceny,	r's Signatu	NA.							

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 () Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gwendolyn Porter 2009 /Medical 6:43 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Joseph Richey Baltimore If Under 1 Year | If Under 24 Hrs. Hospice 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6 Sex 7. Age (In vrs. last birthday) Months Days Hours Min 1□ M 2□ F 65 Director 219-40-6975 4-16-1943 MD Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evantimer must be mailined at MD N/A Baltimore TY∑Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 USA Funeral 843 McKim Street Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married permit. Pages 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event Baltimore, Maryland 21215-0036 by If Yes, Give Year or Dates 1 ☐ Yes XXNo Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Adult Day Care Program Assistant N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Coates Henry Porter ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisa Porter-Daughter 4915 Goodnow Road Apt E Balto, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Pk 3-5-2009 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Bril. Mr 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4/11/05 FING /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown icate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 □Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{Other}} \) Other (Specify) \(\text{\text{TOS PICE}} \) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 🗓 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) alherine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 N. Sudaw St Poulto Richer Hospia 5. HAIZNISON 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 0 4 2009 Registrar

Gwendolyn

	1 State Registrar	State of Maryland /	•	ment of H ficate of L		_	giene Reg. No 2	009	06660
	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
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aminer	4a. Facility Name (If not institution, give str	reet and number)	41	c. City, Town, or	Location of Death		4c. Cou	unty of Death	
	Manor Care			Under 1 Year	Bethesda If Under 24 Hrs.	0 Date of Bin		Montgo	omery place (State or Foreign
eral	5. Social Security Number 6. Sex	7. Age (In yrs. last b		onths Days	Hours Min.	8. Date of Bir (Month, Da July 19,	y, Year) 1023	Mary	ntry)
once. To Be Completed by Funeral Director	217-18-2091 Usual Residence of Decedent	0.0				July 19,	1923	mary.	Land
	10a. State 10b. County	10c. City, To	wn or Locati	on				1	0d. Inside City Limits
햙	Maryland Montgomer	Chevy	Chase	е					1 X Yes 2 □ No
Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
la I	8906 Montgomery Av	enue		20815			Unite	d State	es
Funeral	11. Marital Status	!. Was Decedent Ever in U.S. Armed Forces?	13. Was	Decedent of Hes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tyes 2 □ No If Yes, Give WWII	1 🗆	Yes 2 No	Specify:		Sp	ecify:	
pé		Year or Dates:	a Deceden	t's Usual Occup	ation		16h Kind d	of Business/Inc	White
Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give kind		luring most of work	ring		5. Duoi 1000, 111	
l w	Elementary/Secondary (0-12)	College (1-4or 5+)	Suppl	Ly Chief			Telep	hone C	ompany
BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	Maiden Sur	rname)	
2 8	George Lester Brow	'n			Violet	Dewey S	mith		
	19a. Informant's Name/Relationship (Type	e. Print) 19	9b. Mailing A	ddress (Street	and Number or Ru	ral Route Numb	er, City or To	wn, State, Zip	Code)
	Andrea Lynn Peters Sher				ry Avenue	e, Chevy	7 Chas	e, MD	20815
	20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □ Re	20b. Place	of Disposition	on (Name of ory or other place Y	e) Har	Date ch	20c. Locati	ion - City or To	own, State
	4 □ Donation 5 □ Other (Specify)	Crem	atori	um Inc.	i 2,	2009	Bethe	sda, M	aryland
	21. Signature of Funeral Service Licenses		22. N	ame and Addre	ss of Facility Rob	ert_A.	Pumph:	rey Fur	neral Home nsin Avenu
	William A. K	M01173	Bet	hesda,	Maryland	20814-3	501	WISCOI	isin Avenue
	23a. Part 1. Enter the disease, or complication shock, or heart fallure. List only one	clions that caused the death. Decause on each line.	o not enter t	he mode of dyir	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequenc	e of):						
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Physician/Medical	d.								
Ž	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy					23d	. Date of deliv	ery
cial	in the past 12 months? 1 □ Yes 2 🕅 No	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		ctopic pregnanc ther (s <i>pecify)</i> _	y 			Month	Day Year
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by P	Part II. Other significant conditions conti	ributing to death but not resulting	in the unde	rlying cause giv	en in Part I.	23e. Did 1	obacco use	contribute to t	he cause of death?
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	examiner? 1 ☐ Yes 2 X No	spital: 1 Inpatient 2 I ER/	Outpatient	3 □ DOA Oth	er: 4 X Nursing H	ome 5 🗆 Resi	dence 6	Other (Specia	fy)
Certification: To	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b	. Time of Injury	28c. Injur Wor		28d. Describe			
atic	2 ☐ Accident investigation				Yes 2□No				
tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street	, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Rura	al Route Number,
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cal	(Check only 2 Medical Examine	cian: To the best of my knowled er: On the basis of examination	dge, death o	ccurred at the ti	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) an date and pla	nd manner as a ace, and due t	stated. o the cause(s)
Medical	one)	and manner stated.							
2	29b. Signature and title of certifier	1/0		29c. Licens	e Humber		zsu. Date s	igned (Month,	Day, IGAI/
	10 herry	- Klemu	JMC.	1	D35791		Fel	oruary	27, 2009
	30. Name and address of person who con					_			
	Merlyn Vemury, M.I	0. 9801 Georgia	Aven	ue #227	, Silver	Spring,	Mary.	Land 20	1902
State	MAR (14 2009	Chrown B. A.	Tares						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Ye ar February 24 2009 7:34 Terence Rory Powers 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days Hours 1 ☑ M 2 ☐ F 43 10, 1965 NC 244-31-8233 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Prince George's MD <u>Hyattsville</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3922 Longfellow Street 20781 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Morried 2 Married 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Willie Mae Cromartie Edward L. Powers 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willie Mae Powers-McNeil-Mother 406 W 24th St., Lumberton, NC 28358 20b. Flace of Disposition (Name of cemetery, crematory of other place) Bethany Presbyterian Church Cemetery 3-2-09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☑ Cremation 3 Removal from State 4 □ Donation d □Other (Specify) Lumberton, NC 22. Name and Address of Facility Colvin Funeral Home 21. Sign fure of Fuveral Service Usense 1904 Elizabethtown Road, Lumberton, NC 28358 661. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 18MIa disease or condition resulting in death) Due to ar as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 XNo 2 🗆 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural",

traumatic event, the Medical

Department of Health a Important: If item 27 Is any Injury or other trainonce.

and Mental Hygiene.

Director

Funeral

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Completed

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28a-f shov

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and the burial-transit attending p for use as t s been signed by the should be detached certificate ha irector, page 2 director this After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu I Director: d in by the f

or Attending Physician; The law requires that the death certificate be executed

the Hospital

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical Completed by Be

Certification: To Medical

25. Was case referred to medical

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

State Registrar

DHMH 17 Rev 1/2001

5 Pending investigation 1' Natural 2 Accident 6 ☐Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature 29c. License number and title of ifie and.add ss of person who completed cause of death (Item 23a) (Type. Print

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

32. Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2:20 P M Cherry E. Richardson March 3, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Hospice Towson
If Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days Hours Min. Months 1 □ M XXF 297-38-8360 63 Yrs Jan. 6,1946 Ohio Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 1 □ Yes XX No Director MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Austin Rd. 21136 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes XX No Specify Specify: White þ 3 Widowed XX Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4or 5+) Maryland 12 Operations Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin J. Kimmell Lydia E. Szerencses ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Melissa Richardson Daughter 9 Austin Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Inc. 3/4/09 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Septice Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MONTHS Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 3 Probably 4 Unknown 1XYes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 🗷 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 □ Nursing Home 5 □ Residence 6 X Other (Specify) HOSPIC 1∐ Yes 2∭2No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

ng physician and as the burial-transit After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial 68760 Box (Ö Vital Records, Division of il or Attending F gatter death. the illed in by

Funeral

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items 23a

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Physician

/Medical

Examiner

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Baltimore, Maryland 21215-0036

2009

March

Richardson

other traumatic event, the Madical Ever share, ust be notified at

24 hours a within 24 hou

To the Fune

completely fi

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2009

29b. Signature and title of certifie

29a. Certifier

(Check only one)

6565 N CHARLES ST, SUITE 209 BALTMORE, MD 21204 DANIEUE DOBERMAN, MO 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D64395

29d. Date signed (Month, Day, Year)

MARCH 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day ELEN 2029 MARCH 2009 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) WESTMINSTER CARROLL CARROLL COUNTY GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 3/26/1911 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min 1 ☐ M 2 ☐XF MĂŘŸĽAND 218-12-4791 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐XNo SYKESVILLE CARROLL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA 6490 SACRAMENTO DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 💢 No Specify WHITE 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPARTMENT STORE SALES PERSON 10TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ELSIE HAYMAN UNAVAILABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6490 SACRAMENTO DR. SYKESVILLE, MD MICHAEL REESE/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) DULANEY VALLEY MEM. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/4/2009 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) GARDENS Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licen Le Mo1139 21286 8521 LOCH RAVEN BLVD. TOWSON, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nimutes brovascu Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2,21No 2 No 1 □Yes 1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

e Hospitai or Attending Physician: "he law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, prige 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To

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State Registrar

Physician

Examiner

Director

Funeral

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ament of Heath and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, If a Maryles Exprise 1, ust by undiffed at ury or other traumatic event, If a Maryles at 1

Department of Health Important: If item 27 any injury or other troops.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

25. Was case referred to medical examiner?

3 Suicide determined 4 Homicide 29a Certifier

Elders burg

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MD

29b.	Signa	ature	and	title	of certifier
			11		

MUSH

29c. License number 33681 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1380 Progress Way M. MCEVOY

MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature



within 24 ho

To the Fune

completely f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death Q 52 \lambda 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 25, 2009 ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) Hours 1 ☑ M 2 ☐ F 214-56-4009 BUST 2, 1950 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 □ No Director BALTIMORE MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number MONROE STREE Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces,

1 MYes 2 No
If Yes, Give 69-02-191/
Year or Dates: 8-73-1972 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CISCO PACKAGE HANDLER YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RAGINS WAKE JULIA ERVIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ST.,BALTIMORE,MDQlQ11 NOVELLA R. RAGINS (WIFE 2009 N. MONROE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST CEM: 03/04/2009 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 2140N. Fulton Avenue MD 21217 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐Yes 2 ☐ No 1 □Yes After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2√No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

D

29a. Certifier FX Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Manth, Day, Year) 29b. Signature and title of certifie

State Registrar

Medical

31. Date filed (Month, Day, Year)

lackowlas

32. Registrar's Signature

		•	For State Registrar	State	of Maryla	ind / Dep <i>Ce</i>	artment of F	lealth a	and M	R	leg. No.	09	06665
	Dhuaiai		1. Decedent's Name (First, Midd.							Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		Luzie	Ε.	Rupn	ik				FEB	1	2029	3-15AM
	Examin		4a. Facility Name (If not institution	-			4b. City, Town, o				100	ty of Death	
			Sanctuary a				Burto					tgome	
	Funeral Director		5. Social Security Number 229-54-4654	6. Sex 1 ☐ M 2 ☐ X	,	s. last birthday, Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Birth Month, Day 10/3!	1924	9. Birthpl Count Gern	lace (State or Foreign try) Nany
	and w		Usual Residence of Decedent 10a. State 10b. County	,		City, Town or L						11	0d. Inside City Limits
	Mary!	lor	MD Monte	gomery		Burton	sville						1 ☐ Yes 2X No
	with the a or 28a-	Direct	10e. Street and Number 3415 Greence	astle F	load		10f. Zip Code	866	V		10g. Citizen of USA		itry?
	ne 23	era	11. Marital Status	12. Was I	Decedent Ever in	U.S. 13.	Was Decedent of H	Hispanic Ori	igin? (Spe	ecify Yes or No-	14. Ra	ice - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or Itame 23a or 28a-f show importent: if item 27 is marked other than "natural", or Itame 23a or 28a-f show yilly injury or other traumatic event, the Medical Excitting round be notified at ance.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Mai 3 🔀 Widowed 4 ☐ Divorce	rned 1 TY	d Forces? es 2 X No , Give or Dates:		If Yes, specify Cubin	an, Mexicar Specify:		Rican, etc.)	Speci	ack, White, 6 ify: Wh	etc. .ite
ğ	2 hou	ted	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	oation	t of work	ina	16b. Kind of E	Business/Inc	dustry
Maryland 21215-0036	s within 7. piene. r than "n the Medi	omple	(Specify only higher Elementary/Secondary (0-12) 1 0		ge (1-4or 5+)		e kind of work done DO NOT use retire Iomemake		I OI WOIKI	, ig	Own	Home	9
ğ	il Hygie other	Be C	17. Father's Name (First, Middle	Last)				18. Mothe	er's Name	e (First, Middle,	Maiden Suma	me)	
<u>a</u>	Aental Aental rked o	To E	Otto Jetzor	k				Ge:	rtru	d Stei	nbach		
ary	should and Men s marks tumatic		19a. Informant's Name/Relation	ship (Type, Print)			ing Address (Street						
	1 and 2 Health a tom 27 is		Paul Dennis	/Nephew			Samuel		_	_			
or c	of He of He roth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 DRemoval f	rom State	 Place of Disp cemetery, cre 	osition (Name of ematory or other pla	ce)		Date	20c. Location		
<u>Ĕ</u>	Pages nent of I ent: If ite ury or o		4 □Donation 5 □Other (Specify)	Join Glais	Chesar	eake Cr	em.3	/04/	2009	Belts	ville	e,Md.
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeçal Service	Licensee	2		HTETPAND 241 Col						E,P.A. g,Md20910
	77		23a. Part1. Enter me disease, o shock, or heart failure. Lis	r complications that only one cause	hat caused the on each line.	eath. Do not er	nter the mode of dyi	ng, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	124	1	124	EIMEI	25	I	7 mE	NITH	1	Onset and Death
	/Medical		resulting in death)	a. Du	e to (or as a cons	-						•	
	Examiner		Sequentially list conditions	b									
11/	ם ב	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D ue	e to (or as a cons	sequence of):							
K	siclan and burial-transit	Examiner	that initiated events resulting in death) Last	c	0 to /or os 2 000s	coguence of):						- 1	
760,	te be ex ysiclan a ne burial	E	, sadding in additi, and		e to (or as a cons	sequence or).						1	
876	~ × e	dlcal		d									
). Box 68	The law requires that the death certificat tite hes been signed by the ettending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □ L 4 □ P	i, outcome of pre- ive birth 2 F Pregnant at time of Johnown	etal death 3	□Ectopic pregnanc	:y				Date of delive Month	ery Day Year
P.0	that the de ned by the e detached f		Part II. Other significant condit	ions contributing	to death but not	resulting in the	underlying cause or	ven in Part	L	23e. Did to	obacco use co	entribute to the	ne cause of death?
Š	ires tl signe	ğ	RENAL	,	FFICE		ariabily ing baddo gi			1□Y	res 2□No	3 ☐ Prob	pably 4 Dinknown
Vital Records,	w require been si should I	Completed	1,000		, ,								
Sec.	e law	Jdu								24a. Was autop perfor	an 240 sy rmed?	prior to cor death?	psy findings available mpletion of cause of
౼		S								1 ☐ Yes	2 No		212 No
VIII.	ician: certific ector.	Be	25. Was case referred to medic examiner?	al Hospital:			i O:	her /		h (Check only o			
of	Phys this al dir	2	1 Yes 2 No	1	1 Inpatient 2 Date of Injury	2 ER/Outpatie	ent 3 DOA	N	ursing Ho	me 5 ☐ Resid			ý)
L C	ing After une	lo lo	1. Natural 5 □ Pend		Month, Day Year		Wo	ork?]Yes 2. [1No				
Division	Attending r death. ector: After by the fune	lca	3 ☐ Suicide 6 ☐ Could	1 got bo	Place of Injury - A	t home, farm, s	treet, factory, office					n <i>ber or R</i> u <i>r</i> a	al Route Number,
Θ	or Attendate death Director:	Certification:	4 Homicide	t	ouilding, etc. (Spe	ecify)	,			City or Tou	vn, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C		I Examiner: On t			ath occurred at the t nvestigation, in my						
	To the within 2 To the complet	Me	29b. Signature and title of certif		1		-	se number		4	29d. Date sign	4	
	- SH 0		1 Tania	X	alla	Qua	D	283	-95	-	3/3	109	
	11		30. Name and address of perso	n who completed	cause of death (Item 23a) (Type	Print)		Λ		1-1		21208
	10		TASNEEM	LA		ri, 28	35 Sm	177-1	H	TE, B	ALID	MD	21201
S.	St	ate	31. Date PAR 0. 4 200	19 Sens	32. Registrar's Si	ignation							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year March 3, 1:58 Maude Lucille Rohlsen 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Gilchrist Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
New Jersey 5. Social Security Number 7. Age (In vrs. last birthday Days Hours 1 ☐ M 2 🔀 F 215-22-4886 8/29/1926 82 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Towson MD Baltimore 1 □Yes 2 ▼No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21204 1065 Donnington Circle Apt A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Stevenson Samuel R.S. Barclay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 Willowbrook Drive Cary, NC 27511 19a. Informant's Name/Relationship (Type. Print) Andrew Barclay / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 3/6/2009 Timonium, Maryland Maryland 21204 e, Inc. 1050 York Road 22. Name and Address of Facility Towson, Ma Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC RENAL CELL CARCINOMA MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence off Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 No 1 ☐Yes 2 ☐No 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HISTICE 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral Director

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Completed

Be (

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Funeral

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be rediffed at once.

Physician

/Medical

attending physician

is certificate has been signed by the director, page 2 should be detached

filled in by the

To the Hospital or within 24 hours a To the Funeral D

Baltimore, Maryland 21215-0036

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Directifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MARCH 3, 2009 DU4395

State Registrar

6565 NOHARLESSTI SUITE 209 BALTIMETE, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIELLE REBEREINAN, MD

MAR 0 4 2009

31. Date filed (Month, Day, Year)

			_ State		/ Depa	delible Ink. artment of F rtificate of I	lealth and I	Mental Hy	giene	e.
Ī	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Lewis Duke Schmidt			imouto or i		2. Date of De Month March		3. Time of Death 5:20pm M
	Examin Funeral Director		212-50-8719 1 [™] X ¹ 2□ F 61	e (In yrs. las	st <i>birthday)</i> Yrs.	4b. City, Town, or Woodbil If Under 1 Year Months Days	ne If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 23	ay, Year)	
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Carroll		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	tth with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 5005 Woodbine Road			10f. Zip Code 21797			10g. Citizen of What	at Country?
020	urs after des al", or Items Examiner m	þ	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 ☑ Yes 2 □ ☑ If Yes, Give Year or Dates:	106	7-	Was Decedent of H If Yes, specify Cuba 1 □Yes 2∑No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Black,	American Indian, White, etc. white
0-01212	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. Or Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	i+)	(Give life, I	dent's Usual Occup kind of work done of DO NOT use retired enance me	during most of wor d)	king	16b. Kind of Busin	
ylallu	2 should be filed within n and Mental Hygiene. Is marked other than raumatic event, the than than the man the than the the than the than the the than the the than the the than the the the the the the the the the the	To Be C	17. Father's Name (First, Middle, Last) Lewis Richard Schmidt				Julia F	'lohr	e, Maiden Surname)	
-	1 and 2 sh Health and tem 27 Is m other traum		19a. Informant's Name/Relationship (Type. Print) Eileen Schmidt (spouse)			ng Address (Street Woodbine			ber, City or Town, St MD 21797	ate, Zip Code)
201	ages 1 ant of He ht: If iten		20a. Method of Disposition 1	cen	netery, cren	sition (Name of natory or other place Forest Vo		Date -OQ	20c. Location - Ci Owings Mi	
Dalemo	permit. Pages 1 a Department of He Important: If item any Injury or othe		21. Signature of Funeral Service Licensee Parage Hought Herbert	odii	22	2. Name and Addre	ss of Facility Hai	ght Fun		e & Chapel
	Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a conseque	nce of):	er the mode of dyir		or respiratory a	arrest,	Approximate Interval Between Onset and Death 2 1 1 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1
,00/00	leath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	resulting in death) Last C. Due to (or as	a conseque	nce of):					
O. DO.	the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. The thin 24 hours after death this certificate has been signed by the attending physicial mpletely filled in by the funeral director, page 2 should be detached for use as the burnal director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	leath 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	
COIDS, T	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions contributing to death b	ut not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did	¥	ute to the cause of death?
ישרו ומי	Physician: The law r this certificate has be ral director, page 2 sh	Completed	25. Was case referred to medical					1 □ Yes	opsy prior dea 2 No 1 E	ere autopsy findings available or to completion of cause of ath? Yes 2 □ No
5	hysicia this cert	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie			nt 3 DOA Oth	4 LI Nursing H	ome 5 Res	idence 6 □Other	(Specify)
	Attending Phr r death. ector: After thi by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending (Month, Da) 2 Accident investigation 3 Suicide 6 Could not be determined	y, Year) ury - At hom	t8b. Time of Injury	Wor	yat k? Yes 2∐No	28f. Location (or Rural Route Number,
Š	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	O	4 ☐ Homicide building, etc. 29a. Certifier (Check only (Check on					e, and due to the		
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier			29c. Licens		Tred at the time.	29d. Date signed (
•			30. Name and address of person who completed cause of o	21.11	11, 0,	Print)	Prikwa	5 Colu	whix M	1904 and Floys
	Sta Registr		31. Date filed (Month, Day, Year) NAR 0 4 2009 32 (egistr	ar's Signatur	1. 4.	and		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06668 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** 915 A M March 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard Columbia Centr If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Apr 5, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 PA 6. Sex **Funeral** Months 1 □ M 2 😾 F 195-20-7389 85 Apr Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ∐Yes 21∏ No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ber 21044 6334 Cedar Lane USA other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify: 9 Specify: White 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Harold Gates Jessie Hurd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at.
Important: If item 27 is t.
any injury or are. 2159 McKendree Rd., West Friendship, MD 21794 Mrs. Helen Lawrence (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) All County Cremation 3/3/2009 Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, P.A. PO Box 195 Sykesville, MD 21784 Brian MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ischemic edis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760. physician Physician/Medical the the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an certificate has autopsy 1□ Yes 2☑No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1- octifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Division or Vital Records. To the Hospital or Attending I within 24 hours after death.
To the Funeral Director; After

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ndidi Feinbé 6030 Daybreak Circle Swite A150-236 Clarks with MD 21029 NID State Registrar

-43

29b. Signature and title of certifier

29c. License number

AD059423

29d. Date signed (Month, Day, Year)

March 1 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Month 4:57-AM ebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner zabeth Vursina 1 m6 a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 5 1930 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ★M 2 ☐ F 78 214-26-9195 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Illia Madical Exprince must be notified at MD Howard Director Marriottsville 1 □Yes 💹 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1350 Driver Road 21104 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. was December Ever in 0.5.
Armed Forces?
1 ∑Yes 2 □ No 1951—
If Yes, Give
Year or Dates: 1953 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) transportation tractor trailer driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Albert Spindler Sr. Mary Ursula Jarboe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Spindler (spouse) 1350 Driver Rd., Marriottsville, MD 21104 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-4-09 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) Crest Lawn Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Page Haight Sterkert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each toe. Approximate Interval Between Onset and Death Immediate Cause (Final KIN Physician 5 PAV disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner ment Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ibrillation that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) 68760. Physician/Medical attending pl Box IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 🗖 No 3 Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate perform Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 2 1 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ō 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 🗆 No after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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DHMH 17 Rev 1/2001

Baltimore, Mary

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 MD

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 March Smith 4:50 James Μ. Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Woodbine Howard 14728 Carriage Mill If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1 M 2 □ F Days Hours 231-03-8542 87 15 1921 KY Apr Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Woodbine 1 ☐ Yes 2 XNo MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 USA 14728 Carriage Mill 12. Was Decedent Ever in U.S. Armed Forces? 1 TYes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 □ Divorced WWII Year or Dates White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Shop Owner Furniture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Smith 011ie Caudill Isom Litton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Michael Smith (Son) 14728 Carriage Mill Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State MD Burial 2 Cremation 3 N Removal from State 4 Donation 5 ☐ Other (Specify) Fort Hill Cemetery 3/5/2009 Lynchburg, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel 6416 Sykesville Road, Sykesville, MD 21784

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f sho

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, It will define the train once.

Funeral Director

<u>ک</u>

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Physician/Medical ۵ Be Completed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page Certification: To

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	e mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between			
Immediate Cause (Final disease or condition resulting in death)	Onset and Death						
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of): Due to (or as a consequence of):	9 days					
cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	cDue to (or as a consequence of):						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of delivery Month Day Year						
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ving cause given in Part I.		o use contribute to the cause of death? 2 ☑ 3 Probably 4 Unknown			
			24a. Was an autopsy performed?				
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)				
1 ☐ Yes 2 🗷 Kio	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hom	ne 5 🖟 Residence	6 ☐ Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at 2 Work?	8d. Describe how in				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		actory, office 2	8f. Location (Street City or Town, Sta	eet and Number or Rural Route Number, State)			
29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)			
29b. Signature and title of certifier		29c. License number	Date signed (Month, Day, Year)				

DHMH 17 Rev 1/2001

Medical

State Registrar

Sute 201 ELKridge, MB. 21075

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUA HID,

31. Date filed (Month, Day, Year)

LAMZ Brown

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Dete of Deeth 3. Time of Death Shannon Month 2 **Physician** Elsie 4.50 . /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Death 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year)
(L - 13 - 1925 N/A Health and Rehabilitaion

6. Sex A 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1□ M 200F 220-18-4375 Yrs Director MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2□No Director or 28a-f Baltimore N/AMD10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8874 Fontana Avenue 21237 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by Black 3/□\Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Loyola High School Peges 1 and 2 should be filed within nent of Health end Mentel Hygiene. int: If Item 27 is marked other then * Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria 12th grade N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willis Overton Rufus Taylor Mary Elizabeth Ford 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health e : If item 27 is or other tra Timothy Shannon -Son 8874 Fontana Lane Balto, MD 21237 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 3-9-09 Owings Mills, March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2 No 1 □Yes 2 □ No or Attending Physician: 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To Director: After this completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 Tyes 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29b. Signature and fittle of certifier 29c. License number 3 9 1 Blvd. Baltimore MO 21239 me end address of person who completed cause of deeth (Item 23e) (Type, Print) 5601-Loch Raven 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Box 68760.

Division of Vital Records, P.O.

Certificate of Death Reg. No. 2 () () 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eldora Seidel February 11:48 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Dundalk Baltimore North Point Future Care 8. Date of Birth (Month, Day, Year) December 6, 1920 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min Pennsylvania 202-09-2827 88 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location er than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1856 Marshall Road 21222 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify: þ Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, Item May Injury or other traumatic event, Item May Elementary/Secondary (0-12) College (1-4or 5+) 12 years Cafeteria Worker Public School Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Bursel Alexander Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number Rural Regite Number, City or Town, State, Zip Code)
314 Old Canterbury Turnhipe, Norwich, CT. 063 Wilbur Seidel Jr. Norwich, CT. 06360 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Februäry 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 28, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. MIKOM 21222 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any leading to initial cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner the burial-transit and Due to (or as a consequence of): the attending physician and for use as the burial Box 68760, death certificate be Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Yea 5 ☐ Other (specify) P.O. I ☐Yes 2 ☐No detached 9 Unknown 9 I Unknown signed by t The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No ibrillatis 1 ☐ Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: After this of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division **♣**E Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; completely filled in by the f death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ladeu Ste iou Coher 845 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01781 State of Maryland / Department of Health and Mental Hygiene 2009 06673 Frederick Clement Staigerwald 1- For State Certificate of Death Rea. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1941 hrs March 2, 2009 Staigerwald Medical Examiner Clement Frederick 1c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** North Point Boulevard & Saint Monica Drive Dundalk If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral oreign Months Days Hours Country) Maryland November 23,1942 Director 216-40-0920 1. XM 2 66 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 X No Maryland Baltimore Dundalk 28a-f show 23a or 28a-f show Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number USA 21222 7932 St. Claire Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Never Married 2 Married 1 X Yes <u>-</u> Yes 2 X No specify: Specify: White 4 X Divorced If Yes. Give Year should be filed within 72 hours after Widowed "natural" ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 If item 27 is marked other than Protein Plant Operator 12 years of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Garnetta Pierson Frederick Clement Staigerwald Sr. Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 MD 7932 St. Claire Lane, Dundalk, Maryland 21222 Claence O. Staigerwald Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, March 4 20a. Method of Disposition Baltimore, crematory or other place) Removal from State Burial 2 X Cremation 3 Baltimore, Maryland 2009 Bayview Crematory Donation 5 Other Specify. 10 Signature of Funeral Service Licens Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md Approximate interval 23a. Part I. Enter the dis a ..., or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one buse on each line. Death Medical a. Multiple Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran Physician/Medical AMENDED attending physician or use as the burial UNPENDED certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Live birth Fetal death use as 1 past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? has Νo ✓ Yes 2 No 1 🗸 page 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Hospital: Other A Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 this 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury After Pedestrian struck by auto Certification: Mar 2, 2009 0000 hrs Natural Yes 2 V No Pending death. Director: d in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) North Point Boulevard & Saint Monica Dri, Dundalk, MD 3 Suicide Could not be determined (Specify) Local Street To the Funeral 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier March 3, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year)

MAR 0.4 2009

			1 - State Registrar	State of Mary	yland /	Departme Certifica	ent of F ate of	lealth and		giene Reg. No	/	06674		
	- Physici	an	Decedent's Name (First, Middle, Last)			0000			2. Date of De			3. Time of Death		
	/Media	al -	Mae V. Shackert 4a. Facility Name (If not institution, give str	eet and number)		4b. Cit	hv. Town. d	or Location of Deat	Februar	42	. County of Dea			
4	Examir	ier	Citizens Nursin	. 1		Ha	ureD	eGrace			Harfor			
	Funeral Director		5. Social Security Number 6. Sex 1 □ 1 □ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (/	in yrs. last b	Yrs. If Und Month	der 1 Year s Days	Hours Min.		th y, Yea <i>r)</i> 191	9. Bird Co	thplace (State or Foreign buntry) ryland		
- F ₃ AQ_	D		Usual Residence of Decedent 10a. State 10b. County	1/	Oc City To	wn or Location			i Mi Zi		- Mai	10d. Inside City Limits		
	Maryla -f shov fied at	to	Maryland Harford Cou			æGrace						1 ☐ Yes 2 XNo		
	th with the 23a or 28a ust be noti	al Director	10e. Street and Number 200 J. SecretariatDr	ive		10f. 2 21	Zip Code 078				tizen of What Co			
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	. Was Decedent Eve Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:	er in U.S.		cedent of H pecify Cub 2[X No	Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.))-	14. Race - Ame Black, Whit Specify: Wh	e, etc.		
15-0	n 72 h "natu ledical	oletec	15. Decedent's Educa (Specify only highest grade o	completed)	16	a. Decedent's Us (Give kind of v life. DO NOT	sual Occup work done use retire	oation during most of wo d)	orking	16b. K	ind of Business	/Industry		
212	ed withi rgiene. er than , the M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	B	ook Keepe				Hos	pitalit	y Ind.		
Maryland 21215-0036	uld be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) Leo Vogelsang					18. Mother's Na Matilda	me (First, Middle Rosenda		n Surname)			
Mary	d 2 sho th and I trauma		19a. Informant's Name/Relationship (Type Mr. Charles Schadert	. Print) : (San)				and Number or R t Drive,			,,	,		
Baltimore,	Pages 1 an ent of Heal nt: If item 2 y or other		20a. Method of Disposition 1 □ Burial		20b. Place	of Disposition (A tery, crematory of Funeral	lame of		Date	20c. L	ocation - City or t Hill M	Town, State		
Baltin	permit. I Departm Importar any Injui		21. Signature of Funeral Service Licensee	~		22. Name Evans 3 News	and Addre Funera	ess of Facility of Chapel rive, For	. & Crema est Hill	tion Mar	Services Vland 21	- Bel Air 050		
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	itions that caused the	e death. Do							Approximate Interval Between Onset and Death		
	Physician / Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									Those and Dodge		
	Examiner		Sequentially list conditions. b.	mem	W									
4	nsit	mine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to or as a c	onsequence	e of:								
Mi	e exection and urlal-tra	edical Examiner	resulting in death) Last	Due to or as a c	onsequence	e of):								
68760	ficate by physical the post	edica	d	·					_					
O. Box	requires that the death certificate be executed sen signed by the attending physician and tould be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent profinant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	b. If yes, outcome pf 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal dea			у			23d. Date of de Month	livery Day Year		
g.	uires that the de signed by the a id be detached f	by Ph	Part II. Other significant conditions contr	ibuting to death but n	not resulting	in the underlying	g cause giv	ven in Part I.				the cause of death?		
cord	w requir been si should	eted										robably 4 Donknown		
$\mathcal{M}e$ Vital Records,	The lav	Completed							24a. Was auto perfe 1 Yes		prior to death?	utopsy findings available completion of cause of 2 No		
Vita V	Physician: this certific	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	2 🗆 E D/C	Outpationt 201	DOA Oth		ath (Check only					
ert, ision or	Attending Phy r death. sctor: After this by the funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 Envoutpatient 3 DOA 4 Nursing Home						e 5 🗆 Residence 6 🗀 Other (Specify) Bd. Describe how injury occurred				
hacke	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numb City or Town, State)							ural Route Number,			
200	ne Hospita n 24 hours ne Funera oletely fille	Medical C	29a. Certifier (Check only one)		camination a									
	To the within To the comp	Me	29b. Signature and title of certifier War GIM M.	1).		2	nu nu nu nu nu nu nu nu nu nu nu nu nu n	se number		29d. Da	ate signed (Mont			
	2		30. Name and address of person who com	pleted cause of deat	h (Item 23a	(Type, Print)	Mo	/ Vnr	2/07	2		-		
	Sta Regist		31. Date filed (Month, Pay Year) WAR 0 4 200	32 legistrar's	Signature	fort	1	U [7][/	- 0.1	0				

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a er dea h.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760. Division of Vital Records, P.O.

Physician

/Medical

Examiner

Funeral

Director

show

death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Health a

item 27

Department of H Important: If ite any Injury or otl once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Director

2

Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It of Modical Examinan must be notified at

4:00 PM investigation 01-23-2009 2. Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2229 W.SALMOGA 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BALTIMORE MO 21223 HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier M.D 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CENTER DRIVE REISTERSTOWN MO 21136 BUSINESS 31. Date filed (Month, Day, Year)

State Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 10,35 AM SMIT AGNES February 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Carrol1 Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Country)
Maryland 66 217 74 1321 Director 12/20/1942 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 200. any injury or other traumatic event. If a hours any injury or other traumatic event. 10b. County 10c. City, Town or Location 10a State 10d Inside City Limits Director Baltimore 1 ☐ Yes 2Kî No Reisterstown Maryland 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? 131 Westminster Pike 21136 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify à Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Willis Smith ည Thelma Anna Folev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Therese M. Clark / Sister 301 Rain Water Way #201 Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/03/2009 Baltimore, Maryland <u>Cedar Hill Cemetery</u> 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. manuesculls 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final **Physician** ration ASD disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Physician: The law requires that the death certificate be executed the burial-tran Division of Vital Records, P.O. Box 68760、分 resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. the as been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ encephalopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed Retardation 2 1 No 1 ☐ Yes 2 ☑ No After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 [] Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 139JOLMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Main street Westminster Hosain MA 447, East 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GINI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Avenue Apartment West Baltimore Inder 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 219-32-9392 09-01-1937 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Motival Examinating that the notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 X Yes 2 □ No Director N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 826 West North Ave Apt C Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐XNo SpecifAfrican American 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Steel Worker Bethlehem Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginis Samuel Stokes, Sr. Helen Gardner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 West North Ave Apt C Baltimore, MD 21217 Brenda J. Stokes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 03-03-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transi and Due to (or as a consequence of) physician Physician/Medical the aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ੬ MERGONMOI 3 Probably 4 Unknown cate has been signal page 2 should b 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The certificate 2 **X**No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation n 24 hours after death.

In Funeral Director: Aftered filled in by the fur 1 ☐ Yes 2 ☐ No

Box 68760, P.O. Records,

Division of Vital

Maryland 21215-0036

Baltimore,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier (Check only

3 Suicide

4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 North Greene Street Baltimore, Maryland stephanie 31. Date filed (Month, Day, Year)

State Registrar

Medical

within 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** RU /Medical 4c. County of Death 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Northwest Hospice 9. Birthplace (State or Foreign Country) Georgia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1/12/23 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Days 1 □ M 2 □ F 86 216-14**-**8429 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County ral", or items 23a or 28a-f show Evan ther must be notified at 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or i ury or other traumatic event, the Medical Evan and roust be n USA 21207 6102 Meadow Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify 9 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Government Systems Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 01a May McDonald 0. Smith Harry ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212819a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau once. #10 Montrose Manor Ct., Apt I, Catonsville, MD William J. Bradford (Son-in-Law) 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 € Surial 2 Cremation 3 Removal from State Loudon Park Cemetery 3/4/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Louion Park Funeral Rome 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a Barth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROSCLERO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine if any, leading to implede cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the strandism should be seen. Division of Vital Records, P.O. Box 68760, arpithe burial-tra Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 🖫 😘 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. Liçense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Mo

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

Reg. No.20

Physician
/Medical
Examiner

Funeral Director

the Maryland 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Box 68760. phys P.O. þ signed by Division of Vital Records, certificate

Silver Spring 3576 Chiswick Court, 1C | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Washington) | August | 11, 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🖾 F 215-26-0716 79 Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the invidical Examination at the natified at Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 3576 Chiswick Court, 1C 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 ₩idowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 17. Father's Name (First, Middle, Last) Be Benjamin Ritter Mary L. Hastings ၉ 19a. Informant's Name/Relationship (Type. Print) Donna M. Stahr / Daughter Department of Health Important: If item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Marchate2 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Angelette Days M01305 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Metastatic Squamous Cell Carcinoma 24a. Was an autopsy perform 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2⊠No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical 29a. Certifier and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number D0028479 MO 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Uma Prasad, M.D.

1. Decedent's Name (First, Middle, Last) 2. Date of Death February 23, 2009 Mary Phyllis Ritter Stahr 10:13 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Birthplace (State or Foreign Country) 1929 Pennsylvania 10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian Specify: White 16b. Kind of Business/Industry Airlines 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Quince Orchard Blvd., Apt. 21, Gaithersburg, Md 20878 20c. Location - City or Town, State Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 Approximate Interval Between Onset and Death 10 years or more 23d. Date of delivery Month Dav Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) February 26, 2009 10810 Connecticut Avenue, Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 MAR 0 4 2009

		For State Registrar		State of	of Mai	ryland		rtmen <i>tificati</i>				lental Hy	giene Reg. No. (2009	9	06680	
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Funeral Director		5. Social Security Nu 216-20-113	57	6. Sex 1 🔀 M 2 🗆 F	7. Age		st birthday) _ Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da 07/27/19	th ly, Yea <i>r)</i> 926	1 C	rthplace ountry) Iry I a	(State or Foreign	
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and 2 s ealth ar n 27 is ner trau		Joan_Jones,						-				more, MD	-		21p C01	ue)	
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Division To the Hospital or Attenwithin 24 hours after death Within 24 hours after death To the Funeral Director:	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my/opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											d. e cause(s)				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** 320fm Selander Myrtle Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital 8. Date of Birth 1. Month, Day Year) 12-26-1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Mary Tand 1 □ M 2 🛛 F 220-20-0288 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Madical Exprimer must be notified at 1 X Yes 2 No Director N/A Baltimore Maryland 10a. Citizen of What Country? 10f. Zip Code 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21214 U.S.A. 2603 Beechland Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Saltimore, Maryland 21215-0036 1 □Yes 2 X No Specify. If Yes, Give Year or Dates Specify. White δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Magnetic pages. Elementary/Secondary (0-12) College (1-4or 5+) Retail Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Warden Philip D. Wright, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12399 Shue Court Glen Rock, PA 17327 Mrs. Sharon Laney - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/06/2009 Lorraine Park Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 5305 Harford Road 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 **N**o 1 ☐ Yes 1 ☐ Yes this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation. In my opinion, death occurred at the time, date and place, and due to the c 29a. Certifier

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu within 2 To the

Medical

31. Date filed (Month, Day, Year) State MAR 0 4 2009 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or Dahhia Binton 2035 Smith Avanua Svite 203 32. Registrar's signatur

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items of Maryland Department of Health and Mental Hygiene and #8 Per FH G889 3/10/08 DH Certificate of Death Reg. No. 2 amend #8 Per 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Day rank Anthony Sanlag 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3519 BARTON OAKS DRIVE ROAD BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 081-18-2138 85 Director Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MONMOUTH NJ HOLMDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 SWEET BRIAR LANE 07733 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED MANUFACTURING permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SANTAGATA **JOSEPH** ROSALIE **CAPONEGRO** ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3519 BARTON OAKS ROAD, BALTIMORE, MD 21208 MARK KRASNA / SON-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLMDEL CEMETERY 4 □ Donation 5 □ Other (Spe 03/03/2009 HOLMDEL, NJ Re of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. the 9 Unknown á s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð No. 3 Probably 4 Unknown Completed cate has t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ! 1 ☐ Yes 2 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Son-in-law Other: 4 Nursing Home Hospital: 1 Yes →2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi residence 27. Mapner of ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation after death Director: / r death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16 masns mound 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 05/85 vite Touser 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAR 0 4 2009

DHMH 17 Rev 1/2001

09-01736 William Turner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 06683

		For State		Ce	ertificat	e of	Death			1	Reg No.			
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	48	a. Facility Name (if not institution 1309 North Fulton Ave	n, give street and nu	mber)	,	41	City, Town, o	or Location o	t Death		4c.	County of	Death	
Funeral	5.	Social Security Number	6 Sex	7. Age (In yrs	last birthd	ay)	If Under 1 Ye			8. Date of E	Birth (MM/D	D/YYYY)	9. Birthpl Foreign	ace (State or
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AD 2 short h and 27 is matic	2 1	9a. Intormant's Name/Relations WILLIAM C. TUI					854 PE	ACH OF	RCHAR	D LAN	E, BA	LTO.	, MD	21222
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5 4 4 7		29a Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the becaminer:On the basis	est of my know of examination	vledge, deat on and/or in	h occu vestiga	rred at the time	, date and pl non, death o	ace, and o	due to the c the lime, d	ause(s) ar ate and pla	nd marine ace, and o	r as stated Jue to the	cause(s)
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		200 Olg. 12. Circ of Corn	1 21/	11	_			C.M.E.			Ma	rch 3, 2	009	
	-	30. Name and address of person	howbo complained and	Ise of death (Item 2321									ann ann airealta aireann ann ann an Aireann aireann aireann aireann aireann aireann aireann aireann aireann air
1			eputy Chief Med			1 Pe	nn Street, E	Baltimore,	MD 21	201				
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Poniete		MAR U 4 /(K)	J (Maller	1 4.	4000									

State of Maryland / Department of Health and Mental Hygiene 06684 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 28, 2009 Robert A. Troch 12:19 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Balt irore Stella Maris Hospice 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 03/31/193 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 77 218-28-7019 Director Mary land Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-4 show ary Injury or other traumatic event, Ith Medical Examples on other traumatic event, Ith Medical Examples or other traumatic event, Ith Medical Examples or other traumatic event, Ith Medical Examples or other traumatic event, Ith Medical Examples or other traumatic event, Ith Medical Examples or other traumatic event, Ith Medical Examples or other traumatic events. MD Baltimore Glen Arm Directo 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4307 Manorwood Drive 21057 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Lucent Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Electrician Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Troch Mary Borek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4307 Manorwood Dr. Glen Arm, MD 21 057 Jean Troch/ Wife 20b. Place of Disposition (Name of St. John S Catholic 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/06/09 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery By Name and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 2234 21. Signature of Funeral Service Licenses 2 a. P rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Imm - late Cause f inal di - se or condition resulting in death) **Physician** PROSTATE CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and BW that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** Hospital: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA of Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D completely filled i Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one Nurse Practitioner as tated. 29a. Certifier Medical 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State MAR 0 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12:19

FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** 19 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Min Months 1 □ M 2 1 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MAKYLAND Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2123 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: Completed by 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND BALTIMORE permit. Pages 1 and 2 s
Department of Health ar
important; if item 27 is
any injury or other trau 3316 ROSAL 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final CHAPEL+ CREMATION cliseas-e cardiac LAO SCLENOTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-trar Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 5 ☐ Other (specify) 4 ☐ Pregnant at time of death o has been signed by the je 2 should be detached a 🗆 I Inknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 performe rmed? 2 No his certificate h I director, page 1 ☐ Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To this After thi funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division 1 Delatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOOS 8141 march 1, 2009 MD

Registrar
DHMH 17 Rev 1/2001

State

Blyd

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

			for State Registrar	State of N	Marylan	-	artment of F rtificate of			ntal Hy	giene Reg. No.	2019	06686
	Dharaisi		1. Decedent's Name (First, Middle	le, Last)					2.	. Date of De	ath		3. Time of Death
	Physici /Medio		Oscar Pimental						Fe	ebruar	y 23	, 2009	2:15 A. M
	Examir	ner	4a. Facility Name (If not institution		<i>'</i>		4b. City, Town, o		of Death			County of Deat	
	Funeral		Montgomery Hosp 5. Social Security Number		Age (In yrs. I	ast birthday)	Rockvill If Under 1 Year	e If Under	24 Hrs. 8	. Date of Bir		ntgomer	hnlace (State or Foreign
п	Director		144-60-5960	1⊠M 2□F	67	Yrs.	Months Days	Hours	^{Min.} Jι	Date of Bir (Month, Da 11y 4,	194	1 Phi	ippines
	pu 🔪		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	parties						40d Incide Oits Line
	laryla f shov	ō	Maryland Montgo			kvi 11ϵ							10d. Inside City Limits 1 □Yes 2 🕅 No
	the N 28a-	rect	10e. Street and Number	January .	Roc	KVIIIC	10f. Zip Code		.		10g, Citiz	zen of What Co	
	h with	a D	13401 Glen Mil:	l Road			20850				-	ed Stat	*
215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Yes Give	s? ☑ No		Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	lispanic Ori an, Mexicar Specify:		y Yes or No can, etc.)		14. Race · Ame Black, White Specify: Fi	
2-0	72 hot	sted	15. Deceder	it's Education est grade completed)		16a. Dece	dent's Usual Occup	ation	et af wardsina		16b. Kin	nd of Business/	
21	ithin 7 ne. 'r	Completed by	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life.	DO NOT use retire	d) mos	t of working		E1 -	- 4 T	
121	iled w Hygiel her ti nt, th	S	17. Father's Name (First, Middle,	Last)		Exami	ner	10 Math	er's Name <i>(F</i>	First Middle	L	od Insu	rance
Maryland	d be f ental l red ol	Be C	Gualberto Donat						sa Pin			surname)	
aryl	shoule and Me merk	ပ	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailir	ng Address (Street					Town, State, 2	Zip Code)
	and 2 salth a 1 27 Is		Dr. Griselda P.	. Trinidad	/ Wife	13401	Glen Mi	11 Ro	ad, Ro	ckvil	le, 1	Marylan	d 20850
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Removal from Sta	20b. Pl	lace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date	_ 1	20c. Loc	cation - City or	Town, State
ţ	tment tant:		4 □ Donation 5 □ Other (S	pecify)	Mont		Crematorium	, Inc.	March 2009	9		esda, M	
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service	icenaee	M008	96 Ro	bert A. Fum 57 Wisco	phrey r nsin	uneral Ave.,	Home/B Bethe	ethesd sda,	la-Chevy (MD 208	Chase, Inc. 14-3501
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ď.	res that signed b be deta	by Pt	Part II. Other significant condition	ons contributing to death	but not resu	liting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco us	se contribute to	the cause of death?
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ecc	law re as be 2 sho	Completed								24a. Was		24b. Were au	topsy findings available completion of cause of
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-	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifyir Medical	ng Physiclan: To the be Examiner: On the basis and manner	of examinat	wledge, deatl	n occurred at the til vestigation, in my o	me, date an opinion, dea	nd place, and th occurred	due to the at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
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			Freien	Wrolfle	tes to	Shy	D006	4615		F	ebru	ary 23,	2009
	15		30. Name and address of person Genevieve Anne					er Mil	11 Rd.				
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 4 2		strar's Signat	ure	w						

DHMH 17 Rev 1/2001

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arlester Vaughn	1-	State of	f Maryland / De	epartment Ce <i>rtificat</i> e	of Health an of Death	d Menta		. No. 200	9 0668
Physician/	_	Decedent's Name (First, Middle,Last)					2. Date of Death		3. Time of Death 0046 hrs
Medical Examine	r		Carlester		Jaughn 14b. City, Town, o	r Location of	Month February 2	7, 2009 4c. County of Dea	<u> </u>
	4	a. Facility Name (if not institution, give s 104 South Larue Square	treet and number)		Baltimore	Location of	Deall	40. County of Boo	
Funeral	5	Social Security Number 6. Sex	7. Age (In	yrs. last birthday				(MM/DD/YYYY) 9. B	an
Director		220-66-6994 1XN	1 2 F	52	Yrs. Months Day	ys Hours	Min. 6-19-	-1956 c	ountry) MD
8	U	sual Residence of Decedent	I10c	City, Town or L	ocation				10d. Inside City Limits
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Aaryland 28a-f show 1 at once. ector	}	MD N/A	1	Balt	imore 10f. Zip Code		10	g. Citizen of What Co	untry?
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with t		Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13	. Was Decedent of H	ispanic Origi	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
or items 23		Never Married 2 X X Married	1 Yes 2v v	No	Yes 2x X N			Specify: B]	ack
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5-0036 iled within 7 Hygiene. 4 other than the Medica		12th grade	N/	A M	aintenan				
Hygie Hygie dothe		7. Father's Name (First, Middle, Last)	Unk				s Name (First, Middle, N herine Va		
2121: Duld be fill Mental B marked ic event,		9a. Informant's Name/Relationship (Type	oe, Print)	19b. M	lailing Address (Str		ber or Rural Route Num		te, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Intent 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Funeral Director	- 10	Charlene Vaughr		12	1 Fourth	Aver	ue Balto	MD 212	27
re, N I and Thealth Fitem		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place of D crematory	isposition (Name of c or other place) US Memor		Date 3-5-2009		
MOI Pages lent of smt: I		4 Donation 5 Other Specify:	, Kemovar II om Otato					Arbutus	3, MD
Baltimore, MD 21215-005 germit. Pages I and 2 should be filed withit Department of Health and Mental Hygener Important: If item 27 is marked other ti injury or other traumatic event, the Mec	1	21. Signature of Funeral Service Licens	ee		22. Name and Addre		March I h Avenue	East F/H	MD 21202
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Division of Vital Records, tal or Attending Physician: The law requirers after death. "al Director: After this certificate has been s leed in by the funeral director, page 2 should 1	Completed							2 ✓ No 1	Yes 2 No
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IVISIOI or Atteno after death Director:	<u>≅</u>	2 Accident Investigation 3 Suicide 6 Could not	be 28e. Place of Injur	y - At home, farr	n, street, factory, offic	ce building, e	tc. 28f. Location (or Town,		Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director	Certification:	4 Homicide determined	(()	h-A- d
e Ho 124 P e Fur	ह	29a. Certifier 1	:On the basis of exemin	nowledge, death nation and/or inv	n occurred at the time restigation, in my opin	e, date and pl nion, death o	ace, and due to the cau ocurred at the time, date	se(s) and manner as s and place, and due to	the cause(s)
To the within To the comple	Medi	29b. Signature and title of certifier	and manner stated	$\overline{}$		ense number		29d. Date signed (
	_	Calesis	\mathcal{N}	1	0.	C.M.E.		February 27, 2	2009
6		30. Name and address of person who					ilin area:	<u> </u>	
J			stant Medical Exa		Penn Street, E	Baltimore,	MD 21201		
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer's	Signature	ball				
DHMH 17 Rev 1/20		THE V T ZIII	w perm	ORI	GINAL			NAME.	_

Physicians of Case Seminor Processors (Case Seminor Processor) (Case Se			State of Maryland / Department of Health and Menta 1-For State Certificate of Death Registrar	Reg. No. 2009 056
2733 Hugo Avenue 2703 Hugo Avenue 3704 Hugo Avenue 3705 Hugo Av		an/	1. Decedent's Name (First_Middle,Last) Wilson	Month Day Year February 26, 2009 0521 hrs
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The complete of the complete o	fter death wit I", or items ? Ier must be r		1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, F 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Puerto Rican, etc.) White, etc.
The complete of the complete o	36 iin 72 hours a :. han "natura dical Examir		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind in the property of the property o	se retired)
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The content of the completion is a consequence of the control of t	t, MU ZI and 2 should ealth and Me lem 27 is ma traumatic ev	To	Louis Burniss (Stepfather) 5420 Lewell	an Ave BAltimore, NA 2120
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The part of the pa	OX 68 / 60, and certificate be attending physicism use as the buries.	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	23d. Date of delivery
Accident Suicide Accide	P.O. DC ss that the des gned by the a	by Phy	a Oliviowii	t J. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
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Accident 3 Suicide 4 Homicide Substitute Substitut	ician: 'ician: 's certifio	å	examiner?	
29b. Signature and title of certifier 29c. License number O.C.M.E. OCME Pebruary 26, 2009 30. Name and address of person who completed use of death Titem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	On Or v ending Physath. or: After thi	-	27. Manner of Death Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Pending 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 1	28d. Describe how injury occurred
29b. Signature and title of certifier 29c. License number O.C.M.E. OCME Pebruary 26, 2009 30. Name and address of person who completed use of death Titem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	DIVISI spital or Att tours after de neral Direct	Certifica	3 Suicide 6X Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence	or Town, State) 2703 Hugo Ave
29b. Signature and title of certifier 29c. License number O.C.M.E. OCME February 26, 2009 30. Name and address of person who completed to se of death litem 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	24 h 24 h Fun etely	dical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place one)	
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	thin thin	Me	29b. Signature and title of certifier 29c. License number	
			The day M. Kind To D. O.C.M.E.	DGME February 26, 2009
Registrar	2012			imore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JOSEPH H. WHITTIE, SR. 2009 MARCH 12:45 AM. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours Director 220-09-4854
Usual Residence of Decedent 87 4/12/1921 MARYLAND show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD PARKVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8338 EDGEDALE ROAD 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2**X**☐ No Specify ģ Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, the Mean Jones. 12:45 Elementary/Secondary (0-12) College (1-4or 5+) PRINTER A HOEN 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HUGH WHITTIE MINNIE VOIGHT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8338 EDGEDALE ROAD BALTTMORE, MD 21234
of Disposition (Name of Date 20c. Location - City or Town, State JOSEPH H. WHITTIE, JR./SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY MEM. 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3/5/2009 COCKEYSVILLE, MD CARDENS 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee MO11/39 THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. MD 23a, Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** END STAGE RENAL DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □No been signed by the should be detached of Vital Records, P.O. 9 Unknown JOSEPH WHITTLE 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops, performed: 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ${}_{4} \square$ Nursing Home ${}_{5} \square$ Residence ${}_{6}$ X)Other (Specify) **HOSPICE** 1∐Yes 2XNo 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division or Attending 1 X Natural Injury 5 Pending To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one X Nurse Practitioner as tated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and actiress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State of Maryland / Departm 1 - State Registrar Certific	ent of Health and Men eate of Death	tai Hygiene	2009 06690
Physici	an	Decedent's Name (First, Middle, Last)	2. [Date of Death	3. Time of Death
/Medio	cal	4a. Facility Name (If not institution, give street and number)	City, Town, or Location of Death	bruay 2	County of Death
and the same of th		NW Seasons Hospice K	andallstown nder 1 Year 1 F Under 24 Hrs. 8, D	Data of Birth	Sattimore State of Face in
Funeral Director		315-24:0364 10M 20 F 80 Yrs. Mon	ths Days Hours Min.	Date of Birth Month, Day, Year)	9. Birthplace (State or Foreign Country)
yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
he Mar 28a-f sh offfied	ector	MD Battimor	Zec. Zip Code	100 0	1 ☑Yes 2 ☐ No tizen of What Country?
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fter dear items	Fune	1 DNover Married 2 Married 1 DYes 2 DNo	ecedent of Hispanic Origin? (Specify specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Madical Examiner must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	s 2 No Specify:	100	Specify: Black
215- thin 72 l te.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	osual occupation f work done during most of working Truse retired)	7/10	and of Business/Industry
d 212 filed withi Hygiene. other than		17. Father's Name (First, Middle, Last)	18. Mother's Name (Fire	st, Middle, Maiden	VOT UUTSTUME Surname)
e d ala la	To Be	Wilburn Watson	Maltha	wae	
_ = - 0 -		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add 728	ress (Street and Number or Rural Ro		or Town, State, Zip Code) MDRL MD 21999
iter of		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, cramatory	(Name of Date or other place)	20c. L	ocation - City or Town, State
Baltimo permit. Page Department of Important: If any Injury or		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sprvice Licensee 22. Nam	e and Address of Facility	C CHE	and funeral Service
Ball permi Depa Impol		Valleyen (J. Livere 315	l Bultimore Nat	i Pike (२१२२५)
Physician	6 6	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart tartire. List only one cause on each line. Immediate Cause (Final disease or condition	mode of dying, such as cardiac or res	spiratory arrest,	Approximate Interval Between Onset and Death
/ /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
xecuted and III-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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Box 68 leath certific attending p		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant	* 17.0		23d. Date of delivery
vision of Vital Records, P.O. Box Attending Physician: The law requires that the death cer order. After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	Physician/N	in the neet 12 months? I Live Dirth 2 Li Fetal death 3 Li Ecto	pic pregnancy er (specify)		Month Day Year
1S, P.(res that th signed by be detact	y Phy	Part II Other significant conditions contributing to death but not resulting in the underlying	ing cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Cords w require been sig	Completed by	Theumonia		1 ☐ Yes 2	No 3 Probably 4 Unknown
Rec	omple			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital Records, siclan: The law requires to sertificate has been signe irector, page 2 should be considered.	Be	25. Was case referred to medical examiner?	26. Place of Death (Ch	1 □Yes 258No neck only one)	o 1 □Yes 2 □No
on of ding Phys	n: To	1 ☐ Yes 2 Mo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death AND Natural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year)		5 Residence Describe how inju	6 Dither (Specify) Tup: Cupiry occurred
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Division all or Attend is after death all Director: ed in by the f	Certification:	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office 281. I	City or Town, State	nd Number or Rural Route Number, e)
To the Hospital or veryith 24 hours after To the Funeral Direct completely filled in bigging and the funeral Direct comple	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence of my knowledge of			
To the within To the comple	Me	29b. Signature and title of certifier MD	29c. License number	29d. Da	ate signed (Month, Day, Year)
10		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	D158/2	Feb	may 24, 2009
10		HAROLD BOB, 25 MAIN	street 2.	1136	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** Williams Sr. George 2009 R. March 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 7031 Ridge Road Frederick 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number **Funeral** Days Min Months Hours 1 € M 2 □ F 84 7/13/1924 Director 196-18-3693 PA Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedest Eventual parameter and the design of the majority of the medical Eventual parameters. 1 ☐ Yes 2√√No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7031 Ridge Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 1943-45 White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Builder 12 Builder/Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Menta h and Mental Joyce Richardson Bovd H. Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar of Health a Peggy Williams/Wife 7031 Ridge Rd., Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 3/5^P2009 Department of Important: If it any Injury or o tx Burial 2 ☐ Cremation Dulaney Valley Mem. Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signal re of 23a. P. rt1. E yer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line.

Imprediate yause (Final Approximate Interval Between METHSTATIC MANCREATIC **Physician** di lease of condition re ultim in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) the as been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 2 🗆 No 1 TYes 72 or Attending Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one, Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the 1 after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 131761 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 W. SEVENTH ST. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06692 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 28 2009 9:20 A Ethelind L. Weidner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year December 18 5. Social Security Number 9. Birthplace (State or Foreign Min. Hours 212 28 5017 Months Days 1 ☐ M 2 ☐ x F 1929 Baltimore Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State Y□Yes 2 No Maryland Baltimore Baltimore County 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21218 USA 3007 Mathews Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) Housekeeping - Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George E Burck Lizette M. Lindeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Mathews Street Baltimore Maryland 21218 Audrey M Norwood (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory March 2 2009 Baltimore, Maryland re of Funeral Serviced, icensee 22. Name and Address of Facility
Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ZANCI monta disease or condition resulting in death) (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Hlnknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

> burial-transit and

attending physician for use as the buria

signed by the a

veral Director; After this certificate has been si filled in by the funeral director, page 2 should be

completely

within 2 the

e Hospital or Attending P n 24 hours after death. e Funeral Director: After t

Physician/Medical

2

Completed

Be

Certification: To

Medical

The law requires that the death certificate be execu

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Вох

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Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 death with

23a

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Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, ITA Ma once.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

altimore, Maryland 21215-0036

5

Director

Funeral

2

Completed

Be

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traumatic event, the Medical Examiner must be notified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 Yes 2 No 3 Probably 4 Unknown

Was an autopsy performed?
Yes 2 100000 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 🗆 No

25. Was case referred to medical examiner? 2. No 1 ☐ Yes 27. Manner of Death

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS PLG 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2009 FESTENAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

works ST TOWSIN MO N

State Registrar filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06693 State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Dennis M. Williams, Jr. 1:50 /Medical Facility Name (If not institution, give street and number 4b. City, Town or Location of Death County of Death **Examiner** 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Y 09-17-1973 Birthplace (State or Foreign Country) (In vrs. last birthday) Age **Funeral** Year) Months Days Hours Min 216-88-4813 35 MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 144 Akin Circle USA or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. ģ Specify: African American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Manager McDonald's 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dennis M. Williams, Sr. Gwendolyn Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Williams/Step Mother 705 N. Woodington Road Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion 03-06-2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 638 N. Gilmore Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rneumony disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Due to (or as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 s autopsy perform certificate ha rector, page 2 1 ☐ Yes 2 X No 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation eral Director: / filled in by the fi 1 ☐ Yes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day,

Va

Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February Meionie Webb 26,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Regional Hospita George's aurel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)

 Country) 5. Social Security Number 7. Age (In yrs. last birthday) 37 Yrs. Date of Birth (Month, Day, **Funeral** Months Days Hours 244-45-6241 1 ☐ M 2 🂢 F Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryls Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 N No Director Beitsville Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7715 Alloway In 20705 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married African American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Family Therapist Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Rozzelle Gary Grier ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Matthew Webb / Husband 7715 Alloway In. Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial March 5, 2009 Minthill, NC 22. Name and Address of Facility Wylie Funeral Home of Baltimore County 21. Signature of Funeral Service License 9200 Liberty Road Randallstown, Md. 21133 Parl 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction Myocardia **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Shoc Deptic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia Due to (or as a consequence of) P.O. Box 68760. nis certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident s after dea. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Slgr and title of certifier 29c. License number D0067210

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State Registrar

31. Date filed (Month, Day, Year)

MAR 0 4 2009

400 West

32. Registrar's Signature

7th Street Frederick, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink	
State of Maryland / Department of State of Maryland / Department of Certificate of	2 40011 111 11 11 11
1. Decedent's Name (First, Middle, Last) Physician	2. Date of Death Month Day Year 3. Time of Death
/Medical John Anthony Joseph Ward	Month February 25, 2009 6:15 PM or Location of Death 4c. County of Death
St Charles Villa 603 Maiden Choice Lane Catons	ville Baltimore
Funeral Director 5. Social Security Number 6. Sex 1 \overline{\text{N}} M 2 \square F 94 Yrs. Months Days	
Usual Residence of Decedent	
Maryland Baltimore Catonsville	10d. Inside City Limits 1 □ Yes 2 ☑ No
Maryland Baltimore Catonsville Maryland Baltimore Catonsville Maryland Maryla	10g. Citizen of What Country?
ទី និទី ២ 603 Maiden Choice Lane 212	228 U.S.A.
4 8 8 9 9 9 9 11. Marital Status 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
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John Aloysius Ward	Mary Elizabeth Breen
19a. Informant's Name/Relationship (Type. Print) Fellow Priest 19b. Mailing Address (Street Print) Fellow Priest 5408 Role	and Avenue Baltimore, MD 21210
Rev. Thomas R. Ulshafer, S.S. 5408 Rola 20a. Method of Disposition (Name of cemetery, crematory or other plants)	Date 20c. Location - City or Town, State
1 Na Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sulpician Cemeter Sulpician Cemeter	
Elementary/Secondary (0-12) College (1-4or 5+) 5 + Roman Catho 17. Father's Name (First, Middle, Last) John Aloysius Ward 19a. Informant's Name/Relationship (Type. Print) Fellow Priest Rev. Thomas R. Ulshafer, S.S. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature) of Funeral Service Ucensee 22. Name and Address June 1. 23. Signature) of Funeral Service Ucensee 24. Donard J	Datelinore, maryland 21214
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Victor Guitierezze-Almeida **UNK UNK**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06696

		For State			Certificate	of E	Death					Reg. No.		
Physicia edical Examir	n/ 1	egistrar Decedent's Name (First, Mic Victor Mai	errez A	1meida						2. Date of Death Month Day Year March 3, 2009			3. Time of Death 0005 hrs	
Edical Exami		4a. Facility Name (if not institu			Imerac	- 1	. City, Town Baltimor		cation of I				ounty of Dea	
Funeral Director		5. Social Security Number	6. Sex		rs. last birthda	y) Yrs.	If Under 1 Months	Year Days	If Under	Mirc		6, 198	Fore	Birthplace (State or eign Country) Mexico
yns		none Usual Residence of Decedent 10a. State 10b. Cour			City, Town or		n				nug.	<u> </u>		10d. Inside City Limits
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Md 2 alth alth ann 2	Į Į	20a, Method of Disposition			20b. Place of	Disposi	ition /Name	of cem	etery,		Date	20c. Lo	cation - City	y or Town, State
Bal'imore, permit Pages I al Department of He Important: If ite		1 X Burial 2 Crem		oval from State	E1 Pante	eon l	er place) Municij	al d	le	3/1	2/2009	9 Xona	acat1	an, Mexico
Bal'imo permit Page Department c Important: injury er otl		4 Donation 5 Other	r Specify: vice Licensee		Santiag	22. N	lame and A	ddress	of Facility	-			PO Bo	ox 195
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3876 rtifica iing ph	an/N	COL Miles deserted seconds	t in the	Live birth			etal death		Ectopi	c pregna	ncy	'	Month	Day Year
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Division of Vital Records, P.O. Box 687 Ital or Attending Physician: The law requires that the death certifures after death. In all Directors. After this certificate has been signed by the attending and present forces of director mose? A should he detached for use as the forces of director mose? A should he detached for use as the second of the period of the peri	P. P.	Part II. Other significant c	100		ut not resulting	in the	underlying	cause g	given in P	art I.				te to the cause of death?
P.O s that	<u>ā</u>										1	Yes 2 ✔	No 3	Probably 4 Unknown
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Division of Vital Rec pital or Attending Physician: The I ours after death.	S		edical				2	6.Place	e of Death	(Check				
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FP Programmer of C	2	27 Manner of Death	28	a. Date of Injury	28b.	Time of	Injury 2	8c. Inju	ry at Wor	rk?	28d. Desc	ribe how inju	ry occurred	olved in a motor
on Con Con Con Con Con Con Con Con Con C	tion	1 Natural 5	Penaling	(Month, Day, Yea lar 1, 2009		7 hrs			Yes 2 ¥		vehicle a	accident		
r Atte r Atte ler des irecto	fica	2 ✓ Accident 3 Suicide 6	Could not be	Be. Place of Injur	y - At home, fa	arm, stre	eet, factory	office	building, 6	etc.	28f. Locat or To	ion (Street a wn, State)	nd Number	or Rural Route Number, Ci hurch Road, Clarksville
Dital o	Certification:	4 Homicide	determined (S		Roadwa									
Hosy 24 ho Fund		29a. Certifier 1 Certify	ing Physician: To	the best of my l	knowledge, de	ath occu	urred at the	time, o	iate and p n, death o	olace, and occurred	d due to the at the time,	date and pla	d manner a ice, and due	s stated. e to the cause(s)
Division of Vital B To the Hospital or Attending Physician: within 24 hours after death. To the Futueral Director. After this certif	Medical	one) 2 Medica	andii	nanner stated.	TIALIOTI AITU/OF				se numbe			29d.	Date signed	(Month, Day, Year)
	Ž	29b. Signature and title of	certifier				290		.M.E.			1	ch 3, 200	
		tancely)	uthall, 1	M)	-16 /H - 22 ·									
4		30. Name and address of Pamela E. South		ited cause of de istant Medic	atn (Item 23a) al Examine	er 1	11 Penn	Stree	et, Balti	more,	MD 2120)1		
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State of Maryland / Department of Health and Mental Hygiene of Certificate of Death 1. Decedent's Name (First, Middle, Last) Anthony Dexter Biglow 2. Date of Death **Physician** February 19,2009 8:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Nursing & Rehab. Ctr. Clinton Prince George's 8. Date of Birth June Day Year) 1966 Seath of Foreign Washington, D.C. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ☐ M 2 ☐ F **Funeral** 7. Age (In yrs. last birthday) Days Hours 42 577-02-8075 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner nust be notified at 1 ☐ Yes 2 ☐ No Director Fort Washington Maryland Prince George's 10e. Street and Number 23 Arthur Drive West 10f. Zip Code 10g. Citizen of What Country?
United States 20744 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene, and Health and Is marked other than "natural", or items 23. If yo or other traumatic event, the Medical Examine in the Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (3-4or 5+) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Biglow, Sr. Dreamer E. Hope ပ္ 19a. Informant's Name/Relationship (Type. Print)
Dreamer .E. Biglow (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 Chalk Level Rd., Louisa, Va. 23093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ott February 28 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Site Louisa, Va. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Thomasson Watson Funeral Service, Inc. 117 West St., Louisa, Va. 23a Jent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line to Approximate Interval Between Onset and Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Hepatic Encephalopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral inverted injector, page 2 should be detected for use as the burnal-transit Pneumonia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical Chronic Obstructive Pulmonary Disease IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Bacteremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed. 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∄No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide For Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 2 Medical Exa 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) February 25, 2009 30. Name and address of person who completed Arstoo Yazdani, M.D. ause of death (Nem 23a) (Type, Print) , 9135 Piscataway Rd., Clinton, Md. 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

09-01775 Brittany Bradshaw Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06698

		- For State tegistrar				C	Certificate	of I	Death				F	Reg. No.			
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any		10a. State	10b. County			10c. 0	City, Town or L										Inside City Limits
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5-0036 led within 72 Hygiene. other than	E		(First, Middle	e. Last)				_	18.Mother's Name (First, Middle, Maiden Surname)								
T. filed	Bec	17. Father's Name (First, Middle, Last) Jody Bradshaw							Joan Hamlett								
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To:B	19a. Informant's N	ame/Relation	ship (Tұ	pe, Print)	ontia	19b. N	ailing	Address	(Street	and Num	ber or Ru	ural Route N	lumber, Cit	ty or Town, S	tate, Zip	Code) 2111
and 2 shoul leath and N tem 27 is in transmatic		Paula 1	TOEL.	io-{	8010	maror-	50 20b. Place of D					, s	uite Date	204	OW1	ngs	Miffs;
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Baltimo permit Page Department o Importants injury or oth		2/. rignature of Fu			ee A	MAN		Ma 43	ame and r Ch OO W	f7h	of Facility Wes	st Ave,	Bal	timo	re, M	id	21215
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiène Important: If item 27 is marked other than "natural", or items 23n or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Sec			oilege (1-4 o			egal sec	retary	У	ľ			agemen	t
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death for their certificate has been signed by the attending physician from helely filled in by the cineral director, page 2 should be detached for use as the burial	sician/Medio	IF FEMALE: 23b. Was deced past 12 mor	nths?	in the 1	Live birt		2	Fetal death Other (Specif		opic pregnan	су	Mont	h	Day	Year
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Division tal or Attendi rs after death al Director: 1	catio	1 Natura 2 Accide	nt	Pending Investigation	28e. Place	of Injury - A	At home, farr	n, street, factory,			28f. Location or Town,	(Street and N	lumber o	or Rural Route	Number, City
Divisior Hospital or Attend 44 hours after death Funeral Director:	Certification:	3 Suicide 4 Homic	ide	Could not be determined	(Specify)						due to the ca	use(s) and ma	anner as	stated.	
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V	04-4	Partiela 31 Date filed				egistrar's Sig									

Registrar

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2, Day 200 gear March **Physician** 18:30 M Florine Porter Bachman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis 8. Date of Birth (Month, Day, Sept. 3 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. 1□M 2\(\vec{\text{\tin}}}}}}} \end{ent}}} F}}}}}}}}}}}}}}}} \end{\text{\text{\$\text{\tint{\text{\tin}}}}}}}} \end{ent}}} } } } } } }}}}}}}}}}}} \endty}} } \end{ent}}}}}}}} \end{ent}}}}}}}} Months Days Hours 91 1917 579-18-0488 DC **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1203 Hutton Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Be Completed by 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.Chamber Elementary/Secondary (0-12) College (1-4or 5+) of Commerce 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Emily Smith Alexander Porter Windsor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1203 Hutton Drive Glen Burnie, MD 21061 Mr. Sean Thompson/Gradson 20b. Place of Disposition (Name of cemetery, crematory or other place) March 4, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Ave. SW GLen Burnie, MD 21061 ACO1357 fach be 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) JYes 2 ₽No $\mbox{\it inrector}.$ After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 106 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation M 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated 29b. Signature and itle of dertifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_		m 29c555epeMa	Verbod / 1889 Cei	tificate of	Death			
Ь	Physici	an	1. Decedent's Name (First, Mid	dle, Last)				Date of Death Month		3. Time of Death
	/Medic	_	Thomas M. Be				The section of Decili	February		6:15 PM M
	Examin	er	4a. Facility Name (If not institut				r Location of Death		4c. County of Dea	(F)
200	Funeral		2578 Swanton 5. Social Security Number		e (In yrs. last birthday)	Swant If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	thplace (State or Foreign
6.	Funeral Director		212-24-0671 Usual Residence of Decedent	1 ∑ M 2□F	80 Yrs.	Months Days	Hours Min.	(Month, Day, May 5,	Year) Co	yland
	land ow		10a. State 10b. Coun	ty	10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary Fied a	to	MD Garr	ett	Swanton					1 □Yes 2√□No
	3a or 28a st be not	al Director	10e. Street and Number 2578 Swanton	Road		10f. Zip Code 215	561	10	g. Citizen of What Co USA	puntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ M 3 □ Widowed 4 □ Divorce	If Yes Give	No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
Ö	2 hou	ted	15. Deced	ent's Education hest grade completed)	16a. Dece	dent's Usual Occup	oation during most of work	ing 1	6b. Kind of Business	/Industry
21215-0036	within 7 iene. than "r he Med	Completed	Elementary/Secondary (0-12		5+) life.	rmer	d)	,,,g	agricultu	re
9	illed I Hyg other	Be C	17. Father's Name (First, Midd	e, Last)			18. Mother's Name	e (First, Middle, M	aiden Surname)	
lan	uld be Aenta rked tic ev	To B	John Walter B	eckman			Elsie Z.	Miller		
Maryland	2 short and h		19a. Informant's Name/Relatio			•			City or Town, State,	Zip Code)
	and lealth m 27		Richard D. Be	ckman/son			Road Swar		21561	T
altimore,	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☑ Donation 5 ☐ Other	n 3 □ Removal from State	20b. Place of Dispo cemetery, crea	osition (ivame or matory or other pla	ce)	Date 2	Oc. Location - City or	Town, State
Balt	permit. Departi Importi any Inj		21. Signature of Funeral Servi	S. Wade; Vix			ess of Facility Comy Board MD 2120		Baltimore	Street
	Physician /Medical Examiner	3r	Immediate Cause (Final disease or condition resulting in death)	aa. Due to (or as	d the death. Do not entine.		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, it airy, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
P.O. Box 6	0 0	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	y		23d. Date of de Month	livery Day Year
	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant cond	itions contributing to death b	out not resulting in the u	inderlying cause gi	ven in Part I.		acco use contribute to s 2 No 3 P	V.
I Records,	The ate h	Completed		7				24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
or Vital	Physician: Th r this certificate ral director, pag	Be C	25. Was case referred to med examiner?					h (Check only one		
7	hysic this o	1º	1 Yes 2	Hospital:		0			nce 6 Other (Spe	ecify)
ion	ding Afte fune	tion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pen 2 ☐ Accident inve	ding 28a. Date of Inju (Month, Da stigation		Wo	rry at rrk?]Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	after dea after dea Director d in by th	Certification:	3 Suicide 6 Cou 4 Homicide dete	rmined 200. Flace of III]	jury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (Str City or Town	eet and Number or R State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		yIng Physician: To the best cal Examiner: On the basis of and manner st	of examination and/or in					
	To the Ho within 24 to To the Fu completely	Me	29b. Signature and title of	6	_	29c. Licen	se number	29	d. Date signed (Mon	th, Day, Year)
	->-0		180	11/	<u> </u>	D2397	9		2,249	
			30. Name and address of pers				hine i am			
		to.	31. Date filed (Month, Day, Ye	alski,M.D., 3			Kland, MD	21220		
	Sta Regist		MAR 05	2009 Person	rar's Signature	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elmer Cleveland Chesgreen , Sr. 0103 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, 3/14/1917 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min. 1**%** M 2□ F 216-05-8796 91 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examinar must be notified at Maryland Howard Elkridge 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6616 Pheasant Drive 21075 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lift Truck Driver International Harvester 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Chesgreen Maude Lang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Chesgreen - Son 6616 Pheasant Drive, Elkridge, Md.21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3/6/2009 Meadowridge Memorial Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Gary L. Kaufman Funeral Home, Inc 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease, Multiple Stens **Physician** Artery /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed pertension Dive to (or as a consequence of physician Box 68760. Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🔊 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union mermonal hospital, Battimore 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009 5:20 A. M DOLORES CONIFF March ELAINE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Oak Crest Village Care Center Parkville 8. Date of Birth (Month, Day, Mar. 5, 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign 5. Social Security Number Hours 1 M 2 TF Months Davs Min. Maryland 89 214-12-9944 Mar. Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ▼No Parkville Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8810 Walther Boulevard Apt. 2011 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years Financial Counselor Medica1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McGinn **Blanche** Insley Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn C. Becker (Daughter) 3736 Spring Falls Ct. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory March 4, 2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland ^{22. Name and Address of Facility}
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee reman 23a. Part 1. Element the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) erebrovoscular Due to (or as a consequence of): Sequentially list conditions, if one leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown POTOSIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantment must be notified at

Baltimore, Maryland 21215-0036

(3)

attending physician and for use as the burial-transit signed by the a page 2 should has After this certificate

law requires that the death certificate be executed of Division Hospital or Attending

Box 68760, Records, Vital

State Registrar

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 10 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Certification: To fo the mosphase within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 1 🗂 Natural 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MAR 0 5 2009

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene me, 8839,03/05/09dhb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Month 3:15 P M March 1, Del Sheppard Callas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1 □ M 2 🖾 F 1929 Virginia 79 April 8, 212-28-1484 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City 1 □Yes 2 🖾 No Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21042 USA 11625 Ouarterfield Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛛 No Specify Specify 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joel Sheppard Muriel Willey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11625 Quarterfield Drive; Ellicott City, MD 21042 Karen Kennedy Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 3/4/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Martician 21. Signature of Euneral Pervice License MO1537 1630 Edmondson Avenue; Catonsville, MD 21228 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner?
1 ⚠ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 5 Pending investigation Place of Injury - Af MUKNOWN 1 ☐ Yes 2 No DUNN 2 Accident

Location (Street and Numb City or Town, State)

29d. Date signed (Month, Day, Year)

ELLICOTT CITY.

TIMONIUM, MD 21093

attending physician and for use as the burial-trar Vital Records, P.O. been signed by the should be detached Hospital or Attending Physician; Division of

SHEPPARD CALLAS

Examiner lan/Medical

Physician

/Medical

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Funeral

Director

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d other than "natural", or items 23a or 28a-f shovevent, "m "walcal Expresses "ust be retilled at

Department of Health and Mental Hygis Important: If Item 27 Is marked other i any injury or other traumatic event, II

Physician /Medical

Examiner

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

MARCH 1,

within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Physic
6
Be Completed
Be
Sertification: To

F 3 F 5	
(10)	
Sta Registr	
DHMH 17 Rev 1/2	001

30. Name of rest of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) MAR 0 5 2009

6 ☐ Could not be

(Check only 2 Medical Examiner: On the basis of examiner Nurse Practition papers stated.

Place of Injury - At hon building, etc. (Specify)

4 Homicide

29b. Signature and title of certifier

29a. Certifier

At home, farm, street, factory, office

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Home

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

d Ttem 10e per fb. 889-03/05/09dbb

			1 - State Amend Item 10 (Registrar 1.) 1. Decedent's Name (First, Middle, Last)	e per fh, g88	9,03705 Cer	109dhb tificate of	Death	2. Date of De	-	009	06706
В	Physici /Medi		thomas (pates				Month 3	Day	Year OG	1:43 PM
0	Examir		4a. Facility Name (If not institution, give st Toseph R.Ch 5. Social Security Number 6. Sex	El Hosp	(C. last birthday)	4 4 4 2		Apple	4c. County	of Death	ace (State or Foreign
	Director		218 - 46 - 8310 Usual Residence of Decedent	W ZUF EL	Yrs.			10-5-	1976		Miss
	death with the Maryland rms 23a or 28a-f show rmust be rollited at	ctor	10a. State 10b. County		ity, Town or Loo					10	d. Inside City Limits 1
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 4361 Sheldon A			10f. Zip Code	1/3		10g. Citizen of	What Country	ry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1		Vas Decedent of fYes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, et y: B/A	n Indian, c.
Maryland 21215-0036	within 72 h iene. than "natu re Medical	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life, L		pation during most of work ed) MAN SER	I	16b. Kind of B	usiness/Indu	
od 2	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)			/(0////////	18. Mother's Nam				70
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e, Mar	1 and 2 sho Health and em 27 Is mo		19a. Informant's Name/Relationship (Typ) M. E. IV. E. R. V. B. K. On Mathed (Disputition	ich	1819	moni		AVE B	OHOM	10	2/2/3
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or of		20a. Method of Disposition 1	moval from State	+CAYN	sition (Name of natory or other pla NEI CEN	3-10	Date	BAI-	•	
Bal	permi Depar Impor any Ir)/ S	21. Signature of Funeral Service Licensee	theyer	2	431E	ess of Facility Ph 61:VFR 5-	1 BB	Ho m	0 2	12/17 191
	Physician /Medical	8	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the dea cause on each line. Due to (or as a consec		er the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1; 43 pm 68760,	tificate be execut, d is to be provided as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. c.	Due to (or as a consec	quence of):		=				
109 / 0. Box 6	e law requires that the death certifichas been signed by the attending I te 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Fet. 4 Pregnant at time of 9 Unknown	al death 3 🗆	Ectopic pregnand Other (specify)			l l	te of deliver	y Day Year
3/4 ords, P	requires that een signed b rould be deta	ò	Part II. Other significant conditions continued by the brain by the br		i.	derlying cause gi	ven in Part I.				cause of death?
al Reco	i cian: The law re certificate has be ector, page 2 sho	Completed	accident 1					24a. Was autop perfo 1 □Yes	rmed?	Were autops prior to com death? 1 □ Yes 2	sy findings available pletion of cause of
c Coats	ling Phys	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ırv at	th (Check only o	dence 6/1240th		Hospice
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S City or Tou	Street and Numb In, State)	er or Rural	Route Number,
Ma	the Hospital hin 24 hours a the Funeral mpletely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physi 2 Medical Examine	cian: To the best of my kn- er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	time, date and place opinion, death occur	, and due to the rred at the time,	cause(s) and m date and place,	anner as sta and due to t	ited. he cause(s)
	To the within To the comple	2	296. Signature and title of certifier	ini mi)		29c. Licens	se number -6880		29d. Date signe	gi (Month, D.	ay, Year)
	2		Name and address of person who com	. Harris n	1.7.3	Print)	ory Place	- Sni Le	3 (Bu	6f. 7	D. 21201
	Sta Registi		31. Date filed (Month, Day, Year)	3. Registrar's Signa	Son Son	N.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar				Cei	rtificate of	Death		Reg. No.	2009	06707
	Physicia	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	y Year	3. Time of Death
	/Medic		Marvin	Edwar		er		41 On T	Law Early A David	March		009 County of Dea	9:15 -AM
	Examin	er	4a. Facility Name (If n		e street and number)			Dunda	Location of Deat	.n		altimor	
	Funeral		5. Social Security Num		Sex 7. Age	e (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs		1		thplace (State or Foreign ountry)
	Director		236-32-063 Usual Residence of D	30	⊠ M 2□F	82	Yrs.	Months Days	Hours Min.	08/05/			t Virginia
	yland yland			Ob. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	a-fsl	Director	MD	Baltimo	re	Dund	dalk						1 ☐ Yes 2 🛣 No
	or 28	Dire	10e. Street and Numb	per				10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	s 23a	eral	1533 Les1	ie Rd.	12. Was Decedent I	Ever in 110	2 12 3	21222	lienanie Origin? (9	Specify Ves or No	USA	14. Race - Ame	erican Indian
10	ter de ritem iner	Funeral	11. Marital Status 1 ☐ Never Married	2 X Married	Armed Forces? 1 ∑ Yes 2 □ N			Was Decedent of H If Yes, specify Cub		to Rican, etc.)	,-	Black, Whit	
036	urs al	by	3 ☐ Widowed 4		If Yes, Give Year or Dates:	WW 3	II I	1 ∐Yes 2 ∑ No	Specify:			Specify: W	Mhite
5-0	172 hours after death with the Marylan "natural", or items 23a or 28a-f show Include Experimental De to diffind at	etec	1 (Specif)	5. Decedent's Ed y only highest gra	ducation ade completed)		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. K	ind of Business	/Industry
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the finational Examination of the death	Completed	Elementary/Second	dary (0-12)	College (1-4or 5	i+)	Forem	DO NOT use retired	a)		Q+	eel	
	Hyg Hyg Iher nt, 1	Be Co	12 17. Father's Name (F	irst, Middle, Last)		rorem	an	18. Mother's Na	me (First, Middle			-
lan		To B	Matthew	Charles	Cooper				Cather	ine Coo	k		
Maryland	S E S E		19a. Informant's Nan	ne/Relationship ((Type. Print)			ng Address (Street		ural Route Numb	er, City o	or Town, State,	Zip Code)
	5 # 2 r		Jean E. C		(wife)		J	Leslie I		dalk, MD			Tarria Chaha
Ore	ges 1 If iter or oth		20a. Method of Dispo 1 ☐ Burial 2 ☐	Cremation 3 [Removal from State	1		sition (Name of matory or other place		Date		ocation - City or	
Baltimore,	permit. Pages 1 au Department of Hea Important: If item any Injury or othe once.		Donation 5		WEntombmen	t Hol		11 Mem. (2. Name and Addre		/09/2009			ver, MD
Ba	permit. Pages 'Department of Important; If ite any Injury or of once.		21. Signature of Pulls	era Service Lice	. C	L		7922 Wise	e Ave. I	Dundalk,	MD	21222 D	undalk, Inc.
			23a. Part 1. Ent the shock neart	disease, or com failure. List only	plications that caused one cause on each li	d the death ne.	n. Do not ent	er the mode of dyi	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition resulting in death)	inal	, a	•		vuez to	ME BR	AIN			2 months
1	/Medical		rocalling in dealing	-									
	Examiner			- 1		a consequ							340.00
		Jer	Sequentially list cond	ditions,	b. Lunb	CAN	ICER,						3 years
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,eo, %		al Examiner	Sequentially list concluder, cause. Enter Underlo Cause (Disease or in that initiated events resulting in death) La	ditions, schalt ying njury	b. LUNG	cAn a consequ	ICER,						3 years
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			State Registrar			Ce	rtificate d	of De	ath			Reg. No	200	Q	06	705
	Physicia	an	1. Decedent's Name (First, Middle		oster						2. Date of D. Month March		nna Ye	ar 1	0:30	Death a M
	/Medic Examin	al	Joy 4a. Facility Name (If not institutio				4b. City, Tow	n, or Loca	ation of	f Death	Mar Cri		. County of D		0.50	a M
		eı	Dove Hou	se			Westm	inst	er				Carro	11		
	uneral rector		5. Social Security Number 218-68-7811 Usual Residence of Decedent	6. Sex 1 □ M 2 X F	7. Age (In yrs 51	last birthday) Yrs.	If Under 1 Ye		Jnder 2 ours	Min.	Jan . 7	rth lay, Year)	58 M	Birthplace Country A Y Y	and	Foreign
aryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Nexical Extrainst Loricating at once.	ž	10a. State 10b. County	imore		ity, Town or Lo				**					Inside Cit	
the M	28a-f	Director	10e. Street and Number	TIIIOTC			10f. Zip Coo	de				10g. Cit	tizen of What			
th with	23a or	al Di	400 Symphony	Circle #	274		21	030					US	Α		
er dea	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	Armed F	edent Ever in U proes?	J.S. 13.	Was Decedent If Yes, specify (of Hispar Cuban, M	nic Orig lexican,	in? (Sp Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W		Indian,	
ours aft	ral", or Exami	ρ	3 Widowed 4 □ Divorced	If Yes G	ive		1∐Yes 2∐X	No Sp	pecify:				Specify: W	hite	<u> </u>	
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should nd Me	mark	ပ္	19a. Informant's Name/Relations			19b. Maili	ng Address (St							e, Zip Co	de)	
and 2	n 27 is ner tra		Ms. Nancy Rothw	ell/ Sist			Linda		No							
ages 1	t: if itel		20a. Method of Disposition 1 Burial 2 Keremation				sition (Name o matory or other			3 - 5-	Date		ocation - City OWSON •		State	
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per	any it		· /A/	lys			2. Name and A						id. 212	1		
/Me	sician edical miner	er	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to	caused the dealeach line. 2	tic B	EER (uch as d	cardiac	or respiratory	arrest,		Int On	pproximate lerval Betv nset and D	veen Death
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	by the attending ached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregr birth 2 Fet gnant at time of nown	tal death 3	☐ Ectopic pregr ☐ Other (specif						23d. Date of Month	delivery Day	y Y	'ear
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nding Phys tth.	: After this e funeral di	Certification: To	1 Yes 2 Mo 27. Manner of Death 1 Matural 5 Pendir 2 Accident investi	28a. Date	Inpatient 2 [of Injury oth, Day, Year)	28b. Time o Injury	f 28c.	Injury at Work?			ome 5 Res 28d. Describe			Specify)		00-0
l or Atter after dea	Director	ertifica	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inca Zee, Place	e of Injury - At I ling, etc. <i>(Spe</i> c	nome, farm, str	eet, factory, off	ice			28f. Location City or To			Rural Ro	oute Numb	oer,
e Hospita 24 hours	e Funeral	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To th Examiner: On the and mar	e best of my kr basis of examir nner stated.	nowledge, deat nation and/or in	h occurred at the occurred at	he time, d my opinio	date and on, deat	d place, th occur	and due to the red at the time	e cause(s	s) and manne d place, and	r as state due to the	ed. e cause(s)	
To th withir	To th	Me	29b. Signature and title of certifie	11 P.	MAN	Ω.	29c. Lio	cense nur	mber		_	29d. Da	ate signed (M	onth, Day	(Year)	
	2		30./Name and address of person	who completed cau	se of death (Ite	em 23a) (Type,	Print)	1)0	64	54-)		5	5.0	7	
	')	(31. Date filed (Month, Day, Year)	555 Su	etoce	i for St	rest (165	MIL	Sto	- 140	2115	57			
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Registrar DHMH 17 Rev 1/2001

MAR 0 5 2009

Registrar

State

31. Date filed (Month, Day, Year)

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09-01067 Valentin Delcid

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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alentin Delcid	State of Maryland / Department of 1-For State Certificate of Registrar	
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)	2. Date of Death Month February 5, 2009 3. Time of Death 1006 hrs
	4a. Facility Name (if not institution, give street and number) Viers Mill Road & Twinbrook Pkwy	b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery.
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 F 40 Yrs.	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) April 28,1968 El Salvador
nd show any: nce.	Usual Residence of Decedent 10a. State	Rockville 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 13208 Twinbrook Pkwy.	10f. Zip Code 10g. Citizen of What Country? 20851 El Salvador
or items must be Funer?	1 Never Married 2 X Married Armed Forces? If Yes 2 Y No	be Decedent of Hispanic Origin? (Specify Yes or Noses, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No specify: Salvadorian 14. Race - American Indian, Black, White, etc. Hispanic / Specify: White
.0036 within 72 hours aft giene. her than "natural" Medical Examine Ompleted by	45 Decided State (Considerate black and completed) 160 Deceder	"s Usual Occupation (Give kind of work done ost of working life. DO NOT use retired) Orer Construction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Valentin Argeta	18. Mother's Name (First, Middle, Maiden Surname) Maria Lucia Del Cid Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner To Be Completed by 1	Sandra M. Medrano / Daughter 13208 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Emberal Service Manager	Twinbrook Pkwy., Rockville, MD 20851 tion (Name of cemetery, Date 20c. Location - City or Town, State
Physician M dical xaminer	23a. Parl I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many that in litated)	Approximate Interval Between Onset and Death
to, e be executed system and burial - transit	events resulting in death) Last	per me g893 7-28-09 vt
Ox 6876 eath certificat e attending phi for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Female	tal death 3 Ectopic pregnancy Month Day Year her (Specify)
i, P.O. B ires that the d signed by the lbe detached	,	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown
Records, The law requires ficate has been sig		24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
F Vital Ree Physician: The r this certificate al director, page To Re Cor	25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	
Division of Vital Records, P.O. spital or Attending Physician: The law requires that thours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach.		am 1 Yes 2 X No unknown et. factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in bedrical Certific		or Town, State) Viers Mill Rd & Twinbrook Pkwy Rockville, Md rred at the time, date and place, and due to the cause(s) and manner as stated. tion, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To the Ho within 24 To the For completel	29b. Signature and title of certifier Thereby W. King Try www	29c. License number O.C.M.E. OCME 29d. Date signed (Month, Day, Year) February 6, 2009
ϕ	30. Name and address of person who completed caused death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201
Stat	31. Date filed (Month, Ray Year) 32. Registrar's Signature for the MAR 0.5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 Alma Jean Drummond Tarch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Keswick Nursing Home Baltimore n/a 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Alabama 84 Jan. 31 1925 Director 301-18-5442 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Kes 2 No Directo MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21211 3601 Malden Ave. Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 □ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Needle Pointe** Self-employed traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lonnie Hogan Edith Nunn : 1 and 2 should b Health and Ment tem 27 Is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3601 Malden Ave., Woodberry Baltimore, MD Ms. Barbara Drummond/daughter permit. Pages 1 and Department of Health Important: If item 27 any injury or other tro once. Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/7909 √1 Burial 2 □ Cremation 3 ☐Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Sign ture of Apr ral Servi ... Licen ... Elagle Michael 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebrouasenlar ascident Physician /Medical Due to (or as a consequence of): Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy 4□Pregnant at time of death 9□Unknown Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No ate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

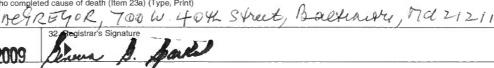
1 □ Yes 2 □ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Beath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Division or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours at To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D13657

12

State Registrar 31. Date filed (Month, Day, Year)

MASELIE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30 PM Month Vear **Physician** Elliott March Judith Roxanne 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner (3) Kiverside camo orien Year | If Under 24 Hrs Social Security Number Age (In yrs. last birthday) If Under 1 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Months Days FEB 29ay 1944 1 □ M 2 T F 65 215-42-5525 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a State 1 □Yes 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director MD Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21001 308 Scenic Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2XX If Yes, Give Year or Dates: 2**X** No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X No Specify: Specify: White þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Health Care Licensed Practical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Jones William Zink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Scenic Drive, Aberdeen, MD 21001 19a. Informant's Name/Relationship (Type. Print) Jennifer Bilsky - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of I Important: If Its any Injury or o 1 ☐ Burial 2 ICremation 3 ☐ Removal from State Metro Crematory, Inc.03/04/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucensee Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performe 1☐ Yes 2 1No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 1 | Inpatient 2 ER/Outpatient 3 DOA P 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

burial-tran and Box 68760. attending physician for use as the buria certificate be the signed by the a P.0. Records, should blue or Vital Physiclan: this funeral After Division spital or Attendi nours after death. neral Director: A filled in by the fu within 24 hours a To the Hospital

Baltimore, Maryland 21215-0036

'natural",

filed withir Hygiene. other than

and Mental

o

is marked

Item 27

State Registrar

Medical

29a. Certifier

(Check only

pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Juse of death (Item 23a) (Type, Print) 30. Name and address of person who completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1230PM Eaton Sr. /Medical Jesse James 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Season's Hospice Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 🔀 M 2 🗆 F Yrs 76 Director 239-48-4538 33 01 09 NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at X☐Yes 2☐No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 6602 Marott Drive 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Be Completed by If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Black 3 Widowed 4 Divorced "natural", 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ss 1 and 2 should be filed within 7 of Health and Mental Hygiene. Item 27 is marked other than "n other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Baker Bakery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Henry Eaton Nettie Solomon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Louise A. Hopkins Eaton 6602 Marott Drive, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place Roanoke Chapel Baptist Church 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/8/09 Littleton, NC 21. Signature of Funeral Serkice Licensee March F/H West Home Thompson 4300 Wabash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENDSTAGE LIVER DISEASE /Medical Due to (or as a consequence of) Examiner irrhosus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as e consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 1 No certificate 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother Specify 1559 (C 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation reral Director: A 1 ☐Yes 2 ☐No 2 ☐ Accident 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical cause of death (Item 23a) (Type, Print) 2835 Smith Avenue Svite 203 Baltimore

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

32. Registrar's Sign

	1- For State Certificate of Death	Reg. No. 2009 067			
Physician/	1. Decedent's Name (First, Middle,Last)	Month Day Year 1247 hrs			
¹ Examiner	Michael Ashton Everhart 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	on of Death 4c. County of Death			
	395 Key Circle Hagerstown				
Funeral	5. Social Security Number 6. Sex 17.795 (iii yis itself)	Inder 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Virginia			
Director	216–48–6235 1X M 2 F 60 Yrs. Moritors Days 15	Feb. 27,1948 Country)Virginia			
> 2	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits			
ow an	MD Washington Hagerstown	1 X Yes 2 No			
a-f sh t once	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?			
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show in the If item 27 is marked other than "natural", or items 23a or 28a-f show in other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	395 Key Circle 21740	U.S.A.			
with the ns 23a be not	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? If Yes, specify Cuban, Mex	Origin? (Specify Yes or No- ican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.			
or items 23	1 Never Married 2 Married 1 X Yes 2 No				
s after ral", c	or Dates:	live kind of work done 16b. Kind of Business/Industry			
hours Fxam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Community Service	NOT use retired)			
hin 72 e. than dical	12				
ed within 72 hour. tygiene. other than "natu the Medical Exan	17. Father's Name (First, Middle, Last)	other's Name (First, Middle, Maiden Surname)			
he file ntal H rked ent, t	Jacob Leo Everhart, Jr. W	inifred Nona Linden Number or Rural Route Number, City or Town, State, Zip Code).			
hould Mer is man aftic ev		Hagerstown,MD 21740			
Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Isnat: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner or other traumatic AD Be Completed by 1	20b. Place of Disposition (Name of cemeter	y, Date 20c. Location - City or Town, State			
permit. Pages l at Department of He Important: If ite injury or other to	1 X Burial 2 Cremation 3 Removal from State Green Hill Cemetery	Berryville, VA			
permit. Pages l Department of H Important: If i injury or other	4 Donation 5 Other Specify: 21 Signature 1 Funeral Service Licensee	acility in ers and Sirrey Funera Home			
permi Depar Impo injur	P.O. Box 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	x 106, Berryville, VA 22611			
Dog leaf	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):				
E E E E	220 27 perMF g889 3/11/	09 TT			
To the Bospital or Attending Physician: The law requires that the death certificate be exewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Live birth 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery Ectopic pregnancy Month Day Year			
by the ached		n in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
es that the signed by pe detacl	26 Place of				
requir been hould		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
ne law te has		1 V Yes 2 No 1 V Yes 2 No			
DIVISION Of VITAI RECOTOS, Ist or Attending Physician: The law requiring after death. "al Director: After this certificate has been sited in by the funeral director, page 2 should be a been an extending the funeral director.	a) 25. Was case referred to medical	Death (Check only one)			
VICE lysicia this ce	O 1 Yes 2 No 1 Inpatient 2 Erooupatient of 201	ner4 Nursing Home 5 Residence 6 ✓ Other: Scene at Work? 28d. Describe how injury occurred			
Jing Phy	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury 31 Yes	at Work?			
ttendi Heath.	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office build				
IVIS I or A after Direc	1 X Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 1 Yes (Month, Day,Year) 1 Yes (Month, Day,Year) 1 Yes (Specify)	or Town, State)			
UVISION To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu		and place, and due to the cause(s) and manner as stated.			
he Ho in 24 he Fu pletely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, date on the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, in my opinion, date of the basis of examination and/or investigation, and the basis of examination and/or investigation.	eath occurred at the time, date and place, and due to the cause(s)			
To t with To t	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated. 29b. Signature and title of certifier 29c. License r				
	Law, mo	E. February 27, 2009			
1	30. Name and address of person who completed cause of death (Item 23a)				
(1)	Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201			
	ate 31. Date of Croth 5 2009 (2. Registrar's bignature)				

09-01636 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert H. Freudenthal State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death B. Time of Death Physician/ Month Day February 25, 2009 1109 hrs **Medical Examiner** Robert Freudenthal Η. 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** 1205 Saint Agnes Lane Apt. K Gwvnn Oak 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 223-64-0109 New York Months Days Hours Director FEB 23 1949 60 1**X** M 2 Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Baltimore Yes 2 X No or 28a-f show itenis 23a or 28a-f sho ust be notified at once. Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 1205 St. Agnes Lane, Apt. K USA with Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, must be Armed Forces?

X Yes 2 1 X Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married utimore, MD 21215-0036

it: Pages I and 2 should be filed within 72 hours after rement of Health and Mental Hygiene. 1966 3 Yes, Give Year White Widowed Divorced Yes 2 X No specify it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner Specify. ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 11 Security Installer Security 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William C. Freudenthal Kathryn Westover Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Freudenthal – uncle 8421 Berea Drive, Vienna, VA 22180 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 03/04/2009 Baltimore, MD Donation 5 Other Specify injury or 21. Signature of Funeral Sprice Licens Import Williams Cremations Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown the hed P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? director, page ✓ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: 1 Other₄ examiner? DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 Residence 6 V Other: Scene this 1 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Director: Pending Yes 2 No hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical To the 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

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LUI

Zabiullah Ali, M.D.

WAR'D 5 2009

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 26, 2009

	For State Registrar	State of M		•		·		2009	06717
		· ·				Month	Day	Year 2009	3. Time of Death
			7)	Col	umbia		4c. Co	ounty of Death Howard	
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If Direct	10e. Street and Number			10f. Zip Code					ntry?
/ Funera		Armed Forces ed 1 ☐ Yes 2 🖸	?	If Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No to Rican, etc.))- 14.	. Race - Americ Black, White,	etc.
edical Exm	15. Decedent's	Year or Dates s Education	16a. l	Decedent's Usual Occi	upation	orking		MITT	
ent, the Me			5+)			me (First, Middle			
To Bo	<u>-</u>	ip (Type. Print)	19b.	Mailing Address (Stree			er, City or T	own, State, Zip	o Code)
other trau	<u> </u>	Son)						ition - City or To	own, State
Injury or e.	4 Donation 5 Dother (Sp.	ecify)	e	Burial Park	North 3/1		San A	Antonio,	Texas
and	debeco			5555 Twin	Knolls Road	Columbia	-	1045 _	Approximate
	Immediate Cause (Final disease or condition								Onset and Death
je je	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of	ry til					years
	cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last	c. <u>Chro</u>	s a consequence of	bstruct	ive lu	ng di	i'sea	Se	years
ysician/Medic	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Fetal death at time of death		псу		230		•
ed by Pi	Part II. Other significant condition	ns contributing to death	but not resulting in	the underlying cause g	iven in Part I.				
page z snu	heart faile	ive, d	ement	5a		auto perfe	psy ormed?	prior to co death?	impletion of cause of
ion: To Be (examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir (Month, L	ijury 28b. T	ime of 28c. Injury	ther: 4 Nursing ury at ork?	Home 5 ☐ Res	idence 6 [fy)
Set in by me	3 Suicide 6 Could no	at ha	njury - At home, far etc. <i>(Specify)</i>			28f. Location ((Street and I wn, State)	Number or Rura	al Route Number,
ledical ((Check only Medical E	Examiner: On the basis	of examination and	d/or investigation, in my	opinion, death oc		, date and pl	lace, and due to	o the cause(s)
	XIAAA		Rec		0419	5			
Cu	30 Name and address of person v	who completed cause of	f death (Item 23a) (Type, Print) Gday (ine #1	63,6	0/00	nhia	MB049
State gistrar	MAR 0.5 20	109 Senter	B. A	alle					

09-Jos

01774 hua Faucette		Please Type or Print in Black Ind State of Maryland / Depart	ment of Health and Merital Hy	/gierre	2009 0671
Carlo de montación de la constante de la const	R	egistrar	ficate of Death	Reg. 2. Date of Death	No. 3. Time of Death
Physicia	177	Decedent's Name (First, Middle, Last) Joshua Faucette		Month Day March 2, 200	ay ^{Year} 1445 hrs
dical Examir		a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
,		911 First Street	Brooklyn Park		Anne Arundel
Funeral		5. Social Security Number 6. Sex : 7. Age (In yrs. las	birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		$220-94-0528$ $1_{X_{M}}$ 2_{F} 30	Yrs.	March 3	30,1978 Country) MD
	**	Jsual Residence of Decedent	own or Location		10d. Inside City Limits
w any		Total Country	oklyn Park		1 Yes 2 X No
f sho	ğ	MD Anne Arundel Broc	10f. Zip Code	10g	. Citizen of What Country?
or 28a	Director	911 1st Street	21225	Ţ	J.S.A.
death with the Maryland or items 23a or 28a-f show any must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S	13 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian, Black, White, etc.
ath w items	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Ricari, etc.)	
	by Fi	3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	wask dano	Specify: White 6b. Kind of Business/Industry
2 hours after "natural", o	٦٩	15. Decedent's Education (opeony anny man-	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel		SD. Nills of Decirios
16 n 72 h nan ".	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	Plumber		Plumbing Company
withi withi giene.	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	i i
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Be C	Louis A. Faucette	Robin	Jean Sou	rs
Mem man	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or 911 1 st Street Broo	Rural Route Numb	ker, City or Town, State, Zip Code)
MD id 2 sho ulth and in 27 is aumati		Mrs. Robin J. Faucette/Mother	loss of Disposition (Name of cemetery.	Date	20c. Location - City or Town, State
re, slan of Hea If iter		4 Removal from State	rematory or other place)	rch 5,	Glen Burnie, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	Iditate Oremater)		Funeral & Cremation
Salt ermit. Separti mpor		21. Signature of Funeral Service Licensee Mol121	Serveies PA 1 2nd	Ave. SW	Glen Burnie, MD 21061
		23a, Part I, Enter the disease, or complications that caused the death.	Do not enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart Approximate Interval Between Onset and
Physician Medical		failure. List only one cause on each line.	xication and cocaine,		
' aminer		Immediate Cause (Final disease or condition resulting in death) a Methadone into	alprazolam intoxicat	ion use	
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- # · · · · · · · · · · · · · · · · · ·	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conseq	f):		
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redeath extens. After this certificate has been signed by the attending physician and extens. After this certificate has been signed by the attending physicial at the state of the state o	<u>a</u>	X UNPENDED X AMENDED 23a,27,	28a-f,perME, g889 3/13	3/09 TT	
760, icate be exe physician at the burial -	sician/Medic	X MENDED 23a, per 23c. If yes, outcome of preg	ME, 2889 3/20/09 II		23d. Date of delivery
Box 68760, e death certificate be the attending physic ed for use as the bur	E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant at time of december 1.	2 Fetal death 3 Ectopic pres	gnancy	Month Day Year
ox 687 eath certific	sicia	past 12 months? 4 Pregnant at time of do	eath 5 Other (Specify)		
BO) he death		Part II. Other significant conditions contributing to death but not it	esulting in the underlying cause given in Part I.		bacco use contribute to the cause of death?
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COFC law re has by	lgu			perfo 1 ✓ Yes	rmed? death? 2 No 1 ✔ Yes 2 No
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ital sician s certi	a	examiner? Hospital: 1 Inpatient 2	ER/Outpatient 3 DOA Other Nu	rsing Home 5	Residence 6 Other: Scene
of Vital Recoing Physician: The law	100	27 Manner of Death 28a. Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred
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Division of Vital Records, P.O. talor Attending Physician: The law requires that the rs after death Is after death In Director: After this certificate has been signed by the talor the condition of the property of the condition		2 Accident Investigation 28e. Place of Injury - At	nome, farm, street, factory, office building, etc.	or Town,	Street and Number or Rural Route Number, City State) 911 First St.
Di pital	Certification:	4 Homicide determined (Specify) 1001 29a. Certifier 1 Certifying Physician: To the best of my knowle	1Se	Brook 1	se(s) and manner as stated.
Division of Vital Rec To the Hospital or Attending Physician: The Is within 24 hours after death To the Fineral Director: After this certificate h	ietely 2		dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
To the	Medical	2 Medical Examiner. On the basis of manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
D &	=	audi? (O.C.M.E.		March 3, 2009
		30. Name and address of person who completed cause of death (Ite	m 23a)		
		Ana Rubio MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21	201	
	Stat	e 31. Date filed (Month, Day, Year) 3. Registrar's Signa	parks		
Reg	istra	MAR 0 5 2009 Persons &	. /		

State Registrar

OCME

			State of Maryland / Department	artment of Health and M	lental Hygie	ene	
				rtificate of Death	Reg	.No.2009	06719
	Dhysisi	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici /Medio		MARY GIBSON		March	1 2009	020M
	Examin	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Season's Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Randallstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Balti:	more
	Funeral Director		251-54-9064 1 M 2 XF 89 Yrs.	Months Days Hours Min.	(Month, Day, Y	ear) Couli	ntry) SC
P			Usual Residence of Decedent				
ırylan	show	_	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits
e Ma	8a-f	ecto	MD NA Balt	imore			1x Yes 2 No
death with the Maryland	a or 2	Funeral Director	3713 Dorchester Road	10f. Zip Code 21215	10g	. Citizen of What Cour	itry?
eath	ns 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	an Indian
fferd	r iter	표	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
5-UUSD 72 hours aff	al'',o Even	Ş	3 K Widowed 4 L Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Bl	ack
2-C	hatu	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/Inc	dustry
j j	han "	dm	Elementary/Secondary (0-12) College (1-4or 5+)			Priva	
led v	Hygie ther t nt, th		3rd grade na 17. Father's Name (First, Middle, Last)	Domestic Worker	(First, Middle, Ma		re
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shoul	and Mental Hygene. is marked other than "natural", or items 23a or 28a-f show aumatic event, tha Madical Exeminer must be notified at	2	Frank Caldwell 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailin Lillie Ida Robinson 726	ng Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip	Code)
Ind 2	f Health and Mer item 27 is marke other traumatic		Lillie Ida Robinson 726	West Saratoga	Street,	Baltimo	re, 21201
s 1 a	or Health item 27 i r other tra		20a. Method of Disposition 20b. Place of Disposition cemetery, cree	osition (Name of matory or other place)	Date 20	c. Location - City or To	wn, State
Pages	ant: If		Manufacture Ma	morial Park 3/7	/09 W	oodlawn,	Md
Dallimor permit. Pages	Department of Important: If it any Injury or once.			2. Name and Address of Facility arch F/H West			
	5 E 8 5		Dunes 13 Tele 14	300 Wabash Ave,			21215
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	· -		t,	Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition resulting in death)	Mrom Bos	ی د		Oliset and Death
	ledical aminer		Due to (or as a consequence of):	27 (30)			
		e.	Sequentially list conditions, if any, leading to immediate b				
J. H	dansit	Examiner	Cause (Disease or injury that initiated events c.				
DIVISION OF VITAL MECOLUS, F.O. BOX 00/00, TO the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death	attending physician and for use as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
o/o	hysici he bu	dical	d				
ertific	ding p e as t		IF FEMALE:				
DOX	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delive	ery Day Year
. å	the shed	Physician/Me	1 Yes 20 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			,
that	Director: After this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
cords, v requires t	n sigr Ild be	d by	A Therescher to Cardie	vacular Da	1 □ Yes	2 □ No 3 □ Prob	ably 4 Hhknown
S §	s bee	lete		,	24a. Was an	24b. Were auto	psy findings available inpletion of cause of
r all	ite ha	Completed			autopsy	d? death?	
an:	ortifica stor, p	Φ	25. Was case referred to medical	26. Place of Death		INo 1 □ Yes	2 🗆 110
hysic	his ce I dire	70 B	examiner? 1 Yes Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other: 4 Nursing Ho	me 5 Residenc	e 6 Other (Specif	Hospice
ding 4	Affer tunera	ii o	27. Manner of beath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	f 28c. Injury at Work?	28d. Describe how		-
VIC Itend	tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐Yes 2 ☐No			
or A	Direc in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	еет, гастоту, оптое	City or Town, S	et and Number or Rura State)	i Houte Number,
spital	neral filled)	29a. Certifier **Sertifying Physician: To the best of my knowledge, deat	h occurred at the time, date and place.	and due to the cau	se(s) and manner as s	tated.
e Ho	To the Funeral I	Medical	(Check only one) Amedical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
To th	To th	M	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month,	Day, Year)
			100 60000	V15872	1	MRCW1,	2009
	4		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		MRCA 1, 136	
	,		31. Date filed (Month, Day, Year) 32. Registrar's Signature	gin sheet	2//	56	
	Sta Registr	-	31. Date filed (Month, Day, Year) ARO 5 2009 32. Registrar's Signature			•	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Kristi Carlson Gunnill February 26, 2009 3:54 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days New York 078-24-0961 62 Director July 30, 1946 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Necles Examination ust be natified. Director MD 1 ☐ Yes XXNo Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 10905 Fiesta Drive 20910 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No <u>\$</u> Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Creative Director Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Frederic Gunnill Elisabeth Nichols Atanasoff 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10905 Fiesta Dr. Silver Spring, Maryland 20910 Frank Kowing (husband) aftimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 27, Feb. Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD. 2009 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its leading to the cause of the Examiner Due to (or as a consequence of): be executed Respiratory Failure physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Advanced Multiple Sclerosis Physician/Medical requires that the death certificate as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No o the 9 Unknown s been signed by t should be detach ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy The certificate of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No this Certification: To 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 X Natural 5 ☐ Pending investigation r death. ours after death.
neral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 26, 2009 manica D 66372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Majid Rahmanianshari, M.D. 1500 Forest Glen Rd. Silver Spring, MD 20910 . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06

		1- For State Registrar		C	ertific	ate of	Death			Re	eg. No.	. 0 0	0012
Physici		Decedent's Name (First, Mid	dle,Last)						2	2. Date of Deat Month		ear	3. Time of Death
ledical Exami	iner	NELSON	GAUS		_					March 1, 2	2009		0228 hrs
		4a. Facility Name (if not institut Sinai Hospital	ion, give street and n	umber)		41	b. City, Town, o Baltimore	or Location	of Death	er .	4c. County	y of Death N/A	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yr	s. last birt	thday)	If Under 1 Ye	ar If Under				Y) 9. Birt Co	thplace (State or Foreign untry)SOUTH
Birector		213-04-5830	1XXM 2 F	L	29	Yrs.	L			08/25/	/1979	CAF	ROLINA
any		Usual Residence of Decedent 10a, State 10b, County	/	10c. C	itv. Town	or Location	n .						10d. Inside City Limits
					•								1 XYes 2 No
Maryland 28a-f show d at once,	tor	MARYLAND N 10e. Street and Number	/A			BALT.	IMORE 10f. Zip Code			1	0g. Citizen of W	Vhat Cour	
more, MD 21215-0036 Pages I and 2 should be filed within 72 heurs after death with the Maryland near of Hard and oldened Hygiene. Intel 18 in the Maryland of the reason and the same and the same and the same and the same and the same replier traumatic event, the Medical Examiner must be notified at once.	Director							014		- 1			itty.
vith the s 23a		3023 WEAVE		ecedent Ever in	ı U.S.	13. Was	∠⊥ Decedent of F	214 lispanic Ori	gin? (Spe	cify Yes or No	U.S.A		ican Indian, Black,
eath ·	Funeral	1 X Never Married 2					s, specify Cub					ite, etc.	
after d	by Fi	3 Widowed 4 D	ivorced If Yes, Give Ye or Dates:		U	1 🗌	Yes 2XXN	o specify.	:		Specify	: BI	LACK
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2121 ould be fill Mental F marked ic event,	To Be	JAMES GAUSE 19a. Informant's Name/Relation			191	b. Mailing	Address (Str.			GASKIN	nber, City or To	wn State	Zin Code)
MD 12 shouth and in 27 is turn afficial	-	Julean Gause/											nd 21214
e, h an i Health item r frau		20a. Method of Disposition			b. Place o	of Disposit	ion (Name of c			Date	20c. Location		
nor lages int of other		1 X Burial 2 Crematic				ory or othe	erpiace) RIAL PA	שט	03-0	07-09	BALTI	MORE	, MARYLAND
Baltimore, MD 21215-003 Departit Pages I an 1.2 should be filed within Importment of St I and T is marked other It Injury or other traumatic event, the Med	3	4 Donation Other 3		1	TING								OME P.A.
	1	X allan (1				LLIAM C				FUNERA	YT HC	ME P.A.
Physician	-	732 Part I. Enter the disease, of failure. List only one caus	or complications that	caused the de	ath. Do no	ot enter the	e mode of dyin	g, such as o	ardiac or i	respiratory arr	est, shock, or h	eart	Approximate Interval Between Onset and
Vedical xaminer	<i>ા</i>	Immediate Cause (Final dise	e a.Stab Wou	nd of Neck									Death
. J. F		or condition resulting in death)	Due to (or as	a consequenc	e of):								
	Jer	Sequentially list conditions, if any, leading to immediate		a consequenc	e of):								
- 21	Examiner	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	C:	a consequenc	e of):								-
ecura and ransit		events resulting in death) Last	d		,-								
rial	Physician/Medical	UNPENDED	AMENDED										
8760, ifficate bug physicas the bug	n/M	IF FEMALE: 23b. Was decedent pregnant in	Alex	, outcome of p		Fets	al death 3	Ectopi	c pregnan	cv	23d. Date of Month	,	y Day Year
Sox 687 leath certific e attending I for use as the	icia	past 12 months?	4 Preg	nant at time of			er (Specify)		- p g a	-,			, , , , ,
Box is death or the attented for us	hys		nknown g Unkr										
ires that the signed by I be detach	by P	Part II. Other significant cond	itions contributing	to death but no	ot resulting	g in the ur	iderlying cause	given in Pa	art I.				the cause of death?
S, F puires m sign Id be	pa												pably 4 Unknown
ord w reg as bee	plet									24a. Was autop	sy	prior to c	topsy findings available completion of cause of
Rec The Is	Completed									1 ✓ Yes	rmed? 2No	death? 1 ✔ Ye	es 2 No
tal Recian: The	Be	25. Was case referred to medic examiner?	<u> </u>				26.Pla	ce of Death	(Check or	nly one)			
hysic r this	၉	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2				Other ₄			Residence 6	Other	7
ion of Vital F tending Physician: ' teath for: After this certifi the funeral director, !		27. Manner of Death 1 Natural 5 Per	Mort (Mont	e of Injury h, Day,Year) 2009	28b.	Time of Inj 5 hrs	· -	ury at Work	. ls	:8d. Describe I Subject stat	how injury occu obed	rred	
SiO Atten r death ector: by the	cati	Fei	estigation		t home fo	rm otroot				Of Leasting /S	Ctroot and Nive	has as Du	red Douge Number Office
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death 25 hours after death 26 therean Director: After this certificate has been sitely filled in by the funeral director, page 2 should the	Certification:	Ca det	ula not be	ce of injury - A		arm, street	, factory, office	building, e			Street and Num State) Road, Baltimo		ral Route Number, City
1 2 2 2 2		29a. Certifier	Physician: To the be			ath occurre	ed at the time	date and ni		··-			ed
To the Hospital within 24 hours 2 To the Funeral completely filled	Medical	(0	aminer: On the basis and manner	of examinatio	-						. ,		
_ F3F8	Se Se	29b. Signature and title of certif		stated.			29c. Licer	se number	_		29d. Date sig	ned (Moi	nth, Day, Year)
		Mull O	~) N	10		0.0	.M.E.			March 1,	2009	
3		30. Name and address of person				444	Done Ct	4 D-₩'-	ne 115	04.004	-		-
)	ate	Russell Alexander M 31. Date filed (Month, Day, Year		Viedical Ex legistrar's Sign		1111	Penn Stree	i, baitimo	ore, MD	21201			
Regis		MAR 0 5 20	22 C	~ A.	po	M							
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Division of Vital Records,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per Verb G889 3/05/09 JH amend 1tems 10b-1 per inf g892 6-15-09 vt Reg. No. 2009 06722 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 02 02 MARCH **GOLDBERG** 2009 4:05 P SYLVIA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WEINBERG STERLING ASSISTED LIVING BALTIMORE N/A Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕽 F Months Days Hours Min 212-07-8401 93 07/08/1915 **Director** Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show N/A Baltimore 1 X Yes Z X NO Director BALTIMORE MD *RANDALLSTOWN 10e. Street and Number 7015 Park Heights Ave 10f. Zip Code 10g. Citizen of What Country? 21215 -8805 SELINA ROAD USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESWOMAN RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Ments 27 is marked traumatice SIMON FRIEDMAN **ESTHER** LAVY ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTA BERNSTEIN / DAUGHTER 8805 SELINA ROAD, RANDALLSTOWN, MD permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of ARLINGTON CHIZUK Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Spacify) 03/04/2009 BALTIMORE, MD AMUNO CONGREGATION 22. Name and Address of Facility re of Fune al Service SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** mun tris /Medical Due to (or as a consequence of): AUZHEIMERS Examiner DEWNENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trar Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Aurtic STENOSIS page 2 should Be Completed ARTERITIS TEMPORAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? URINARY Truct inflictions 1 ☐Yes 2 ☐No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 The Sidence 6 XX ther (Specify) (ASSISTET) L1 V116) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03037 Munch 3,09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mm 6503 PAPUL HEIGHTS AVE Robert M. Cooper 31. Date filed (Month, Day, Year) 32. Registrar's

DHMH 17 Rev 1/2001

Registrar

Amend #1,perMD, g889 3/9/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
PER PHY G889 3/05/09 Jh
PER PHY G889 3/05/09 Jh
Per FH G889 3/11/09 JH
Per FH G889 3/11/09 JH
Reg. No. 2 0 0 amend #1 PER For State Registrar Elwood R. Hall, Sr. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Month **Physician** Ellwood R. Hall, Sr. 2:41 AM 2009 WOOD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore It impe Memorial MOIM if Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min 1**X** M 2 □ F 73 07 30 35 Director MD 219-30-0656 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a, State ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pal1 . 23a r 21215 U.S.A. 3802 Pa1 Mall Road death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify. Specify: þ Black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other thr any Injury or other trainment. Maryland Brush Co. 8th grade Machinist 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Hope Howard Hall Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) India Hall-Wife 3802 Pall Mall Road, Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 3/3/09 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility
March F/H West 4300 Wabash Ave, Baltimore, eth Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) neelas Predior /Medical Due to r as a consequence of) Examiner Stree Sequentially list conditions, sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequen Examiner certificate be executed burial-transit CEDHORU and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9☐ Unknown 9 ☐ Unknown The law requires that Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 ANo Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 X Inpatient ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 0 To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person 31. Date filed (Mo State 5 Registrar

	For State Registrar	State of Maryla		rtment of H		Mental Hy	giene	0 06721
	Decedent's Name (First, Middle, Las	<i>t)</i>				2. Date of De	eath	3. Time of Death
Physician /Medical	Anna N		Hanha	rt		March 3	3, 2009	5:00 A M
Examiner	4a. Facility Name (If not institution, give			4b. City, Town, or		th	4c. County of D	
Funeral	Broadmea 5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	If Under 1 Year	ysville If Under 24 Hrs		th Balt:	imore Birthplace (State or Foreign
Director	213-12-032/	□м 21/2 F 92	Yrs.	Months Days	Hours Min			Covintry) Marvland
land ow	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Loca	ation			,	10d. Inside City Limits
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in the Mar or 28a-f st ce notified Director	10e. Street and Number	7.0	Darci	10f. Zip Code			10g. Citizen of What	Country?
s 23a					1212		U.S.A	
Strer death variet reas 23s incerment	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2♥ No	J.S. 13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (8 n, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
OO36	3 🕅 Widowed 4 □ Divorced	1 ∐Yes 2♥ No If Yes, Give Year or Dates:	1	□Yes 2万No	Specify:		Specify:	White
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ind 2 be filed fal Hyg d other event, Be C	17. Father's Name (First, Middle, Last)	-	_ SLa			ne (First, Middle,	, Maiden Surname)	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. aumanted other than "natural", or items 23a or 28a-f show as marked other than "natural", or items 23a or 28a-f show as marked other than "natural", or items 23a or 28a-f show as marked other than "natural" and	Percy	W. S	Scha11			Jessie	May	Gibbons
	19a. Informant's Name/Relationship (7						er, City or Town, State	
re, N 1 and 1 Health tem 27	Martha L. Hanhart 20a. Method of Disposition			rth Maple tion (Name of tory or other place		Baski Date	Ing Ridge, 20c. Location - City	
MOF Pages nent of int: If its	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	hemoval from State		itory`or other place rvice Coi	i	2000		
Baltimo	21. Sign tun of Funda Lervice Licens		22.	Name and Address	2191		Towson	Maryland
	tank What	an		050 York	Road	Towson,	Maryland 2	21204
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	th. Do not enter	the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Opset and Death
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60, 20 be executed cian and purial-transit	that initiated events resulting in death) Last	Due to (or as a consec	Tuence of):					
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P.O. Box 6 nat the death certific dby the attending petached for use as Physician/Mec	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al déath 3 □ B	Ectopic pregnancy			23d. Date of o	
the de y the s ched f ched f	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5□(Other (specify)			Month	Day Year
IS, P. P. res that signed b be deta	Part II. Other significant conditions co	ntributing to death but not res	sulting in the und	erlying cause giver	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
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I H.A. Iision Attending r death. ector: Afte by the fune	1			M 1 □ Y	es 2 □No			
Divis	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stree fy)	t, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
Hospital Hospital Puneral I Italy filled	29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death o	ccurred at the time	e. date and place	and due to the	cause(s) and manner	a e etatad
Division of Vital Records, P.O. Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physic	(Check only 2 ☐ Medical Exami	ner: On the basis of examina and manner stated.	ation and/or inve	stigation, in my op	inion, death occu	rred at the time,	date and place, and d	ue to the cause(s)
To t vith Vith To t	29b. Signature and title of certifier	Chinal	1 75	29c. License	number		29d. Date signed (Mo	oth, Day, Year)
	Darbara	arrol	7/1	1 L	383	12	3/3/8	009
8	30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, Pri	1 VINRY	RD	CACV	EVEINT	1 F. NA 1030
State	31. Date filed (Month, Day, Year)	32. Registrar's Signe		YUNA	1101	SULA	LXOVIL	11/11/
Registrar	MAR 0 5 2009	Sevent 3.	park		_			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 1, 2009 5:39 A M Arlene C. Halt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore 1235 Pleasant Valley Drive If Under 1 Year _ If Under 24 Hrs. 7. Age (In yrs. last birthday) . Social Security Number 149–34–2113 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🗓 F 21,1945 New Jersey Director 63 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notified at Catonsville 1 ☐ Yes 2 🔀 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 21228 USA 1235 Pleasant Valley Drive Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces 1 ☐Yes 2 🔼 No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ò Specify 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Graphic Artist 12 Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eileen Barett Walter Somick ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ralf D. Halt 1235 Pleasant Valley Drive; Catonsville, MD 21228 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 4 Donation 5 Dother (Specify) c Crematory 3/7/2009 Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Atlantic Crematory 21. Signature Juneral Service Licenses Funeral Home of Catonsville, Inc. any 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition /Medical sequence of): Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and burial-trar Due to (or as a consequence Box 68760, physician Physician/Medical the as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s certificate ! 1 ☐ Yes 2 No Division of Vital 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ■ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manuar of Deat 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 2 Accider 5 ☐ Pending investigation 1 □Yes 2 □ No ours after death.

neral Director: A
filled in by the fu death. Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type,

Year)

MAR 0 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verbal, g289,03/05/09dhb, Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Anna J. Huber /Medical በ3 Ω2 2009 5:42 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ouail Run Assisted Living Parkville, Maryland Baltimore 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 □ M 2**X**□ F Director 215-34-0387 02/12/1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4023 Miller Road Funeral U.S.A. 14. Race - American Indian, Black, White, etc. 21087 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. <u>م</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental is marked Joseph Winkler ၉ Mary Mohr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2255 Schuster Road – Jarrettsville, Maryland 21084 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other trau <u>Melvin R. Huber, Jr.</u> (son) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 03/07/2009 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E. F. Lassahn Funeral Home, P.A 11750 Belair Road - Kingsville, Maryland 21087 60 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARICINSONS
Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner STAGE a consequence of): Sequentially list our differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner EPRESSION attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown been si should I Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy 1∐ Yes 2 No vurs after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division atural 5 Pending investigation 1 ✓ atural 2 ☐ Accident 1 🗌 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō To the Hospital within 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number use of death (Item 23a) (Type, Print) de Place Dundalle MD 2122

DHMH 17 Rev 1/2001

State Registrar

amend #19b Per I'H G889 3/05/09 JH
State of Maryland / Department of Health and Mental Hygiene
amend #23a&b&24b Per OHY G8893/17/09
Gettincate of Death
Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 11:18 PM **Physician** rving Monroe 2009 Damuel Feb /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hospitel of Baltimore City Baltimore Sinai If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Heb 4, 1977 Birthplace (State or Foreign Country) 5. Social Security Number 540-98-8016 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 10M 20F 32 Oregon Yrs. Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b, County 10c. City, Town or Location works | item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No e ovac Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Jo No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) e filed within 7 al Hygiene. Elementary/Secondary (0-12) Cgljege (1-4or 5+) Author 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importsnt: If Item 27 is merked oth sny injury or other treumatic event -rvina samuel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Belationship (Type, Print) 13404 Leesburg Place, Upper Marlboro, MD 20774 Dister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation
4 Donation 5 Other (S 3 Removal from State treenmount 5 Other (Specify) -uneral Serv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kundallstown Ma. 10 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Pulmonary embolism, Bilaterial Approximate Interval Between On DAN Death Immediate Cause (Final disease or condition resulting in death) GOPULMONEVE **Physician** /Medical Due to (or as a consequence of): Examiner CIMONEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ this certificate has been signeral director, page 2 should be Multiple Sclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ZLY NO 1 Yes 2 No 1 X X es or Attending Physician: tor: After this certific the funeral director, 25. Was case referred in medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 1 WNatural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours e To the Funeral C completely filled 29a. Certifier 1 Certifying Physicians To the best of my knowledge, death occurred at the time, date and place, and due to the causa(e) and married as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tytle of certifier 29c. License number 25 34800 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 1-(MO 2200 Kernan Drive Gorman 31. Date filed (Month, Day, Year) Registrar's Signa State MAR 0 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) □2/009 March 1, 6:25A **Physician** ANNE KEITH LEE IRVIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Augsburg Lutheran Village Baltimore 8. Date of Birth Pay, Feb 16, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 16, Yef 924 Months Vîrginia 85 227-20-2056 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at angles. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1XXYes 2 □ No Director Baltimore Maryland None 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21224 1208 South Clinton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ā(Ā) No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🗶 🗖 No White Specify: Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 X Vivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of Alabama Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julia Bird James Keith Marshall Lee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1208 South Clinton Street Baltimore Maryland 21224 DTR Anne Keith Lee Madison Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 Removal from State Mar 2,2009 | Baltimore, Maryland GreenMount Crematory 4 □Donation 5 □ Other (Specify) 22. Name and Address of FaciliMitchell-Wiedefeld Funeral Home Inc ignature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 12heiner! **Physician** rears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Division or Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed use as the bunal-tran and Due to (or as a consequence of) the attending physician hed for use as the bunal Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown After this certificate has been signed by to funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed: autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 12 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tell Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D37570 March 2,2009

State Registrar 30. Name and address of person who completed

Zibel!

57.

ause of Leath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2009 Physician March 3, 5:26 P M Robert Faulkner Jillson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Ruxton 906 Malvern Ave. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) New York 8. Date of Birth July 20, Social Security Number 7. Age (In yrs. last birthday) ,^{Yea}1930 1**火** M 2□ F 121-24-2867 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2**XX**No Baltimore Ruxton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21204 USA 906 Malvern Ave. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ∐Yes 2**XX**No 1 Never Married 2 X Married 1 ☐ Yes 2√XNo Yes. Give Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Textile College (1-4or 5+) Elementary/Secondary (0-12) Converter Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Wynne John D. Jillson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 906 Malvern Ave. Ruxton, Maryland 21204 Cynthia Jillson / Wife Date 20c. Location - City or Town, State 20a. Method of Disposition 3/5/2009 Towson, Maryland Hilltop Serv. Corp. 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears resulting in death) Due (or as a consequence of) Sequentially list conditions, if the line in the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, physician the buria attending p for use as t been signed by the should be detached this in by the funeral After after death Director:

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or items any Injury or other traumatic event, the Medical Example must be a one.

. Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 El Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

State Registrar

CARMC 31. Date filed (Month, Day, 0 5 2009

within 24 hours a

Medical

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Arthur Joseph Jacques March 2009 7:30 P^M /Medical 4a. Facility Name (If not institution, give street and number) Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairfield Nursing and Rehabilitation Crownsville Anne Arundel 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 001-07-3967 Director 102 April 28,1906 Canada Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes Ž No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 301 Cathedral Place 21061 Funeral Canada or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Specify White þ Specify: 3 X Widowed 4 ☐ Divorced "natural", Year or Dates Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: if item 27 is marked other than any Injury or other traumatic event, Ire Magnes. Elementary/Secondary (0-12) College (1-4or 5+) Wood Cutter Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Jacques Delina Vachon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Joyce M. Jacques/ Daughter 301 Cathedral Place Glen_Burnie, MD 21061 20a. Method of Disposition 20c. Location - City or Town, State March 5, 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Atlantic Crematory Glen Burnie, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Singleton Funers1 & Cremation Servcies PA 1 2nd Ave.SW Glen Burnie, MD 21061 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Honknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

MAR 0 5 2009

DAVIS

29b. Signature and title of cert

HUMF

ORIGINAL

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEDICAL PARKWAY

D53111

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND, ITEM#4a&26, perPHYS, G889, 3/5/09, WS
State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First Middle Last 3. Time of Death Physician January 7,2009 Bernice L. Jones AKA Leona Bernice Jones 1215 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number)

-8611 Ridgeville Avenue Examiner Prince George Ft Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 18,1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax **Funeral** 1 □ M 2√2 F Brooklyn NY Yrs 80 101-20-8534 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or than "neturel", or items 23a or 28e-f show the Madical Experiment out be notified at ¥XYes 2 No Director District of Columbia Washington the 10c. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20018 United States 2006 Franklin Street NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 1 Yes 21 No Specify: Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "no American General Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Twe1th None Insurance other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph E. Brown Hattie Patterson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) iges 1 and 2 sl David King/Executor 345 Montgomery St #3D, Brooklyn NY 11225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 January 12. XXBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ö ' 4 ☐ Donation 5 ☐ Other (Specify) 2009 Putnam Ct., New York Rose Hill Mem Park 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 21. Signature of Funeral Service Licensee. Daniel W. Harrison Wifflux 1661 Good Hope Rd SE, Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Acute Renal failure /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ģ in the past 12 months?
1 Yes 2X No 4☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificete has autopsy performed 2 No 2X No 1 Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted **≱** No Hospital: Other: 48Nursing Home 5 Residence 6 X Other (SpecifyLiving 1 🗌 Yes P 1 Inpatient 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. М 2 Accident 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 \(\text{Homicide} \) 24 hours a 1 Cartifying Physician. To the bast of my knowledge, death occurred at the time, date and place, and due to this cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a Cartilla Medical within 24 ho To the Functional 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058797 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingston Rd, Suite 101, Ft Washington Maryland 20744 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical JANOFF MARCH BARBARA 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 XF 10/15/1955 MD 53 213-68**-**0358 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Heatth and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ortant: If item 27 is marked other than "hatural", or other traumatic event, the Medical Examiner must be notified at Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 X No Director OWINGS MILLS BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 3 CLIFFDWELLER COURT 21117 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔏 No 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates: Completed by 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) CUSTOMER SERVICE AGENT SOUTHWEST AIRLINES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be YOSPE RUDOLPH AARON LILLIAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARC HOFFMAN / PARTNER 3 CLIFFDWELLER COURT, OWINGS MILLS, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State permit. Page: Department o Important: If i 03/04/2009 REISTERSTOWN, MD BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Spegify) 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, MD Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one or of on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Onset and Death Sepsis **Physician** days /Medical Due to (or as a consequence of) Examiner Rectal concer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) il or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Immuno suppre ssion

Due to (or as a consequence of): that initiated events resulting in death) Last Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death 5 Other (specify) filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ transplant 1 Tyes 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🗌 No 1 Tes 2 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA ည 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, 4 Momicide City or Town, State) Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Division of Vital Records, To the Hospital or within 24 hours a To the Funeral D

10

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Juster Matthe Backen

MAR 0 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew Bachmonn

Medical

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

2009

March

600 North Wolfe St, Baltimore, MD, 21287

			For		State of M	aryland		artment of F		Mental Hy	/giene		
			- State Registrar			_	Cei	rtificate of	Death		Reg. No.	2009	06733
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	ns 23	Funeral Director	11. Marital Status	Toda	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H If Yes, specify Cub.		Specify Yes or N		14. Race - Amei	rican Indian,
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03	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show deat Exandre mast be notified at	þ	3 ☐ Widowed 4 ☐	Divorced	If Yes, Give Year or Dates:			1⊡Yes 2xi∑xNo	Specify:		,	Specify:	White
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Maryland	d be i	To Be	Brady Wood		nney				Mary	Lavinia	Crab	tree	
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ore,	of He of He roth		20a. Method of Dispositi		Daniel from State	20b. Pla	ce of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Lo	cation - City or	Town, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marcal Exprehence is ust be notified at once.		21. Signature of Funera	al Service Licen	e MQ0053	3							al Home at
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			· ·	ilure. List only	one cause on each l	ine.			-	,	arrest,		Approximate Interval Between Onset and Death
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σ.	requires that the neen signed by th	Y P	Part II. Other significan				ing in the u	nderlying cause giv	ven in Part I.	23e. Did	I tobacco u	se contribute to	the cause of death?
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Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical Certification: To	4 🗆 Homicide	determined	building, e	tc. (Specify)		reet, factory, office		City or To	own, State)	
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			Jonath	han l	orman .	mp		100	2381		03	103/	2009
	15		30. Name and address	of person who	completed cause of Dr Man 32/Regis	death (Item	23a) (Type,	Print)	f. 18 0	of star	+ (1	01. B	nie Milaini
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		For State Registrar	Otate of Mic	•	rtificate of			1. No. 2009	06734
		1. Decedent's Name (First, Middle, I					2. Date of Death		3. Time of Death
Physic /Medi			Корр		1		2 /	28 / 2009	
Exami	ner	4a. Facility Name (If not institution, g 4601 N. Park Av	e. #1018		Chevy	or Location of Death Chase		4c. County of Death	omery
Funeral Director		5. Social Security Number 6. 235-32-2894	. Sex 7. Ag 1 □ M 2 □ XF	e (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Iov.12,19	year) 9. Birth Cot 924 Wes	nplace (State or Foreign untry) t Virginia
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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DESILITIOTE, INTELYISTIC Z.I.Z.I.3-UUJO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Medical Examination in the institute of confined at any injury or other traumatic event, Ita Medical Examination of the process.	/ Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ I If Yes, Give	No	Was Decedent of HIf Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
2-003	ed by	3 🔀 Widowed 4 □ Divorced	Year or Dates:		edent's Usual Occur		16	6b. Kind of Business/I	
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Dall permit Depar Impor any in		21. Signature of Funeral Service Lic	censee	manos i	2. Name and Addre Kapp Fune	eral & Cren Ave., Silv	nation Se	ervices	0910
		23a. Part 1. Enter the disease, or of shock, or heart failure. List or	omplications that caused	the death. Do not en				0,	Approximate Interval Between
Physician	ľ	Immediate Cause (Final disease or condition		oiratory Fa	ailure				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
Lxammer	-	Sequentially list conditions,	D	anced COPD a consequence of):					
executed and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
e exectian an an arrial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):					
58/5 ifficate building physicials the building as the buildi	dical	•	d						
BOX sath cert attendin for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a g □ Unknown	2 Fetal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су		23d. Date of del Month	ivery Day Year
cords, F.O. w requires that the delace signed by the should be detached		Part II. Other significant condition	-	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rdS, quires then an signer and signer	ed by	Atrial Fibrila	tion				1 XX Yes	3 ☐ No 3 ☐ Pr	obably 4 🗆 Unknown
Als or or or	Completed	Hypertension					24a. Was an autopsy performe	prior to o	atopsy findings available completion of cause of
_ + # %		Spontaneous Pn	eumothorax	(11-08)		26. Place of Death	1 □ Yes 2	No 1 □Yes	2 🗆 No
OT VITA Physiclan: this certific ral director,	o Be	examiner? 1 Yes 2 V No	Hospital:	ent 2 ER/Outpatie	ent 3 DOA Ot	hor:		nce 6 □Other (Spe	cify)
On OT VITAI rding Physician: th. : After this certifica funeral director, p	11-1	27. Manner of Death	28a. Date of Inju (Month, Da				28d. Describe how		
SION tending leath. tor: Afte the fune	catic	1 Matural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion		M 1]Yes 2 □No			
pital or Att ours after de eral Direct filled in by t	Certification:	4 Homicide determin	ad 28e. Place of inj	ury - At home, farm, st c. (Specify)	reet, tactory, office	1	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıraı Houte Number,
E Hospital or Attending F 1.24 hours after death. Funeral Director: After		(Check only 2 Medical E	Physician: To the best xaminer: On the basis of	of examination and/or i	ith occurred at the investigation, in my	time, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
o the Porthin 24 o the Formplet	Medical	29b. Signature and title of certifier	and manner st		g 29c. Licen	se number	29	d. Date signed (Monte	h, Day, Year)

To the Hospital or Atterwithin 24 hours after dec To the Funeral Director completely filled in by the

Part II. Other significant conditions of Atrial Fibrilat	ontributing to death but not resulting in the underl ${ ilde{ extbf{i}}}$ on	ying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1XXYes 2 □ No 3 □ Probably 4 □ Unknown
Hypertension			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
Spontaneous Pne	umothorax (11-08)		1 ☐ Yes 2 █ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5XXXResidence 6 □ Other (Specify)
27. Manner of Death 1 M Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, the building, etc. (Specify)	factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Exar	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place gation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)

D12121

MAR 0 5 2009

State Registrar

12

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1538 samuel Lewis James 2009 03 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner imoRe -mo Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min. Months 1 X M 2 □ F Hours 66 Director 06/09/1942 230-52-5433 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modified Experiment, and the rectified at 1 ☐Yes 2 X No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 USA 28090 Van Tassel Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc Armed Forces: 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1961 - 1965 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than * C&P Telephone Elementary/Secondary (0-12) College (1-4or 5+) Management 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be ပ Samuel James Lewis, Sr. Mary Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. Tracy Lewis/Son 7241 Quantico Road Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Mar 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2009 Beltsville, Maryland 21. Signature of Funeral Service Licensee 64410 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Parkinsons /Medical Due to (or as a consequence of): Examiner 30 years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a parsequicing off Examiner the Hospital or Attending Physician: The law requires that the death certificate be execut attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ Pheumon19 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑ No 24a Was an has page 2 autopsy performed? 1 \(\text{Yes} \) 2 \(\text{No} \) No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REENE STREET BALTIMORE, MD 2001 MD Boswell 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State MAR 0 5 2009 Registrar

DHMH 17 Rev 1/200

		1	For State Registrar	State of Mar	yland / [tment of H		nd Mental		ne No.200	9	06736
	Physicia	an	1. Decedent's Name (First, Middle, Last) Theresa C. Lath	e						of Death	Day 2009 Y		3. Time of Death 12:30 P M
	/Medic Examin	-	4a. Facility Name (If not institution, give s Levindale Nursi				4b. City, Town, or Baltimon		Death		4c. County of	Death	
	Funeral Director		212-22-0311	7. Age (in yrs. last bii 81		If Under 1 Year Months Days	If Under 24 Hours	Min. (Mon	of Birth th, Day, Ye 13,	ear)	Coun	ace (State or Foreign try) yland
	e Maryland 3a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD	1	Oc. City, Tow Balti								0d. Inside City Limits 1 Yes 2 No
	n with th 3a or 28 st be no		10e. Street and Number 5450 Cedonia Aven	ue			10f. Zip Code 2120	06		10g.	Citizen of Wha	ıt Coun	try?
736	J within 72 hours after death with the Maryland jiene. Jiene. Than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Events Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.		as Decedent of H res, specify Cuba	lispanic Origii an, Mexican, Specify:	in? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Black, Specify:	White, 6	etc.
9500-6121	filed within 72 hor Hygiene. Ither than "naturi snt, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a	(Give kii life. DC	nt's Usual Occup nd of work done O NOT use retired ery Cle:	during most o	of working		b. Kind of Busin	ess/Inc	lustry
Maryland 2	be filed Ital Hyg Id othe event,	Be	17. Father's Name (First, Middle, Last)	1		0100	ery ore	18. Mother's	s Name (First, N	liddle, Mai	iden Surname)		
aryla		٩	Timothy Joseph Al 19a. Informant's Name/Relationship (Type)				Address (Street	and Number	or Rural Route	Number, C	ity or Town, St		,
Š Š	1 and 2 Health a tem 27 is		Maurice P. Allen	Brother	20b. Place o	of Disposit	Main Fa		rcle; Ca		ville,		
E O	0 0		1 XBurial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify)	lemoval from State	cemete	ery, crema nore	ntory or other place. Nationa	1 3	/5/2009	Ва	ltimore	. M	aryland
Baltimore,	permit. Pag Department Important: I any Injury o once.		1 1000	man Mo	1050	16	Name and Addre Ineral H 30 Edmo	ndson	Avenue;	Cato	nsville	wah	Witzke D 21228
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.		not enter	the mode of dyling of the mode	ng, such as co	end's	tory arrest	ge		Approximate Interval Between Onset and Death
8760,0	The law requires that the death certificate be executed as the law requires that the attending physician and the has been signed by the attending physician and large 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a or Due to (or Due	tunsequente	∍ JI).						+	
O. Box 6	the death certific r the attending p ched for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat		Ectopic pregnanc Other <i>(specify)</i> _	у			23d. Date o		ery Day Year
ds, P.(uires that the de signed by the a Id be detached t	þ	Part II. Other significant conditions co	1 1	not resulting	in the und	lerlying cause giv	ren in Part I.	23e	. Did tobad	. /	ute to th	ne cause of death?
al Records,		Completed	contracti	ines!	-1.					. Was an autopsy performe Yes 2	d? _ prid	ere auto or to con ath? Yes	psy findings available mpletion of cause of
Vital	yslclan: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/O	Outpatient	3 DOA Oth	000	of Death (Check sing Home 5		ce 6 Other	(Specif	y)
o uo	Attending Ph or death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		. Time of Injury	28c. Inju Wo M 1	ryat rk? Yes 2 □ N		cribe how	injury occurred		
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc.	y - At home, f (Specify)	farm, stree	et, factory, office		28f. Loca City	ation (Stree or Town, S	et and Number State)	or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		sician: To the best of iner: On the basis of e and manner state	examination a								
)	To the Hi within 24 To the Fi complete	Me	29b. Signature and little of certifier	rouse Ci	RIP		RG.	FOH ¹	+0	29d	3 /02	Month,	Day, Year)
	lo		M. Elesta 1) 30. Name and address of person who of M. Eletta Morse (ompleted cause of dea	ath (Item 23a)	(Type, P	rint) Seliceolx	ere. A	ve Br	eltir	2007.4	_ ^	אבודי סנ
-4	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's pignature	are	1		1.00			,	

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventian in ust be notified at

Physician /Medical Examiner To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be execute To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

within 24 hours after death.

To the Funeral Director: After this certificate has been

For State Registrar			Ce	rtificate	e of l	Death		Reç	. No. 🤈	nno	0673
1. Decedent's Name (First, Midd	fle, Last)						Т	Date of Death Month	Day	U U ⊃ Year	3. Time of Death
LUCILLE	LIN	NGHAM						February		009	2:05 p M
4a. Facility Name (If not institution	on, give street and num	nber)		4b. City,	Town, or	r Location of De	ath		4c. Coun	ty of Death	
	IS HOSPICE				MONI				BA	LTIMO	
5. Social Security Number 218-05-4414	6. Sex 1 □ M 2 1 1 1	7. Age (In yrs. la	last birthday) 88 Yrs.	If Under Months	1 Year Days	If Under 24 H Hours M	in.	8. Date of Birth (Month, Day,) Feb. 7 1		Cour	place <i>(State or Foreign</i> ntry) YLAND
Jsual Residence of Decedent 10a. State 10b. Count	v	10c. City	y, Town or Lo	ocation						1	Od. Inside City Limits
	ORD CO				GEWO	OD					1 □Yes 2) No
10e. Street and Number				10f. Zip	Code			100	. Citizen of	f What Cour	ntry?
1737 DEARWO	OOD CT.				210	40			U.S.	Α	
11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed For 1 ☐ Yes If Yes, Giv	2 X∑X No ve		Was Deced If Yes, spec 1 □ Yes 2	cify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Spe erto f	ecify Yes or No- Rican, etc.)	BI	ace - Americ ack, White, c rify: BLA	etc.
(Specify only high	ent's Education lest grade completed)		i (Give	edent's Usua e kind of wor DO NOT us	rk done d	during most of v	vorkir		Sb. Kind of I	Business/Ind	dustry
Elementary/Secondary (0-12)	College (1-	-4or 5+)		OUSEW		,			PRIV	ል ጥፎ	
17. Father's Name (First, Middle	, Last)			002		18. Mother's N	lame	(First, Middle, Ma			
SANDERS LEE				ALIC	Έ	LEE					
19a. Informant's Name/Relation	ıship (Type. Print)		19b. Maili	ng Address	(Street			al Route Number, (City or Tow	n, State, Zir	o Code)
Elsie Seward/I	Daughter		2802	Clif	+on	Park Te	rr	ace, Bal	timor	o Md.	21213
20a. Method of Disposition 1 ⊠ Krurial 2 □ Cremation		CC	Place of Dispo cemetery, crei	osition (Nam	ne of					- City or To	
4 □ Donation 5 □ Other (HBURY	U.M.C		03-	-07	-09 W	HITE	MARSH	, MARYLAND
21. Signature of Functor Service	Licensee	*	W	ILLIA	MС	ss of Facility BROWN C	OM A	M FUNERA BLVD, AB	L HOM	E-HARI	FORD, P.A.
23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	st only one cause on ea		h. Do not ent	iter the mode							Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	b. Due to ((or as a consequ	uence of):								
that initiated events ' resulting in death) Last	cDue to (r	or as a consequ	uence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	1 Live b	come of pregnar birth 2 ☐ Fetal nant at time of de lown	Ideath 3	□ Ectopic pi □ Other <i>(sp</i> i		у				ate of deliver	ery Day Year
Part II. Other significant condit	ions contributing to de	ath but not resu	ılting in the u	inderlying ca	ause give	en in Part I.					he cause of death? bably 4 \(\square\) Unknown
							_	24a. Was an autopsy performe 1 □Yes 24		o. Were auto prior to co death? 1 ∐Yes	opsy findings available impletion of cause of
25. Was case referred to medical examiner?)eath	(Check only one)			
1 Yes 2 No	Hospital: 1 ☐ II	Inpatient 2 ☐ £	ER/Outpatie	nt 3□DC	OA Othe	er: 4 🗆 Nursin	g Hor	me 5 Residen	ce 6 X O	ther (Specif	fy) HOSPICE
27. Manner of Death 1 X Natural 2 □ Accident 5 □ Pendi invesi		of Injury h, Day, Year)	28b. Time o Injury	of 2	(Month, Day, Year) Injury Work?						

Examiner Be Completed by Physician/Medical Certification: To Medical

25 27 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Nurse Practitations: 29a. Certifier one) X

29b. Signature and title of

JACKIE

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

2300 DULANEY VALLEY RD. 32. Registrar's Signature CRNP 31. Date filed (Month, Day Year) NAR 0 5 2009

Physician/ 1. Decedent's Name (First, Middle, Last) Annie Wynn Morgan 4a. Facility Name (if not institution, give street and number) Holy Cross Hospital 4b. City, Town, or Location of Death Silver Spring 4c. County of Death Month Day Year 1947 hrs 4c. County of Death Montgomery 4d. County of Death Montgomery	Morgan	1- For State Registrar	State of Maryla		iment of ficate of		ivientai Hy		. No. 200	9 067			
44 Section Name in the contraction of the contracti	Physician/ al Examine	Decedent's Name (First, M.)		gan		-		Month	Day Year 2009				
Section Section Names E. Sec. x 1. App (inlys) isstantionary 1. App (inlys) isstantinopy		4a. Facility Name (if not instit	=	mber)	4			bandary or	4n. County of Death	i			
The control of the	Funeral	⁵ Social Security Number		7. Age (In yrs. las	t birthday)				(MM/DD/YYYY) 9. Bir	thplace (State or			
To Baller DC To Breet and Number 19 Ridge Road 10 Lap Code 10 Lap	Director	227-32-9693	1 X F	81	Yrs.	Months Days	Hours Min.		7, Foreig	n Virginia untry)			
The Street and Number 19 Ridge Road 109 Exception 15 Street and Number 19 Ridge Road 20011 10. Street and Number 19 Ridge Road 109 Ridge Road 20011 11. Market Street of Happer Compress 1 19 Ridge Road 109 Ridge Road 20011 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street of Happer Compress 1 19 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 10 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Only 1 Ridge Road 11. Market Street Road 11. Market Street Road 11. Market Street Road 11. Market Street Road 11. Market Street Road 11. Market Street Road 11	vin.	10a. State 10b. Cour					<u>-</u>						
19 Ridge Road 11. Merial Status 19 Ridge Road 11. Merial Status 19 Ridge Road 11. Merial Status 19 Rever Married 2 Mannel 2 Mannel 2 Married Forces 2 Man 3 X Widowed 4 Movement Pres. Dever Year 2 X No 3 X Widowed 4 Movement Reverse Pres. Dever Year 2 X No 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 3 X Widowed 4 Movement Reverse Pres. Dever Year 4 Year 2 X No 5 Reverse Pres. Dever Year 5 Reverse Pres. Dever Year 5 Reverse Pres. Dever Year 5 Reverse Pres. Dever Year 5 Reverse Pres. Deverse Pre	* ·			Wa	ashing								
12 Marian Status 12 Was Deceded Fiver in U.S. 13 Was Deceded Fiver in U.S. 14 Report Marian 2 Mariand 3 Mariand Status 12 Was Deceded Fiver in U.S. 13 Was Deceded Fiver in U.S. 13 Was Deceded Fiver in U.S. 14 Was Deceded Fiver in U.S. 15 Was Deceded Fiv	or 28a-	10e. Street and Number	dge Road			10f. Zip Code	20011	109		-			
Second Comparison Compari	ms 3a be notil		12. Was Dece							ican Indian, Black,			
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22. Name and Address of Facility J. M. Wilkerson Funeral Estago Internal Part I. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part II. 102 South Ave., Petersburg, Va. 23603 Internal Part III. 102 South Ave., Petersb	atural xamine	15 Decedents Education (or Dates:		6a. Decedent	's Usual Occupatio	n (Give kind of w			Industry			
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O.C.M.E. February 4, 2009 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	To To	29b. Signature and title of ce	and manner s	tated.									
30. Name and address of person who completed cause of death (Item 23a) Pamela E, Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	51	Janaly VI	whall mo			O.C.M	1.E.		February 4, 200	9			
	Kpert					1 Penn Street.	Baltimore, N	MD 21201					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Feb 26 Philip Joseph Marino, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Baltimore Washington Nedical MD Ctr If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-18-1949 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 436-76-3024 59 Director Vew Orlains, LA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No MD Ellicott Director Howar 10e. Street and Number 10g. Citizen of What Country? 21042 464 or items 23a by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITS 3 ☐ Widowed 4 ☑ Divorced Year or Dates: "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If Item 27 is marked other than ' College (1-4or 5+) Trainer Horse Kacino 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Nancy Thresa Marino ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If Item 27 is any Injury or other trau - Métairie Marino Homeslead 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State New Orleans tika from Funeral Home @ 21075 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years Artery disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Onknown 1 Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2. ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

R.6.

State Registrar

BITOTRAJ 31. Date filed (Month, Day, Year) 32. Registrar's Signature

M.D

704

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

D23181

Garman Ave. #T-1

State of Maryland / Department of Health and Mental Hygione

Baltimore, Maryland 21215-0036		de la companya de la	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Wholeni Extra methor that the multiple at once.	Funeral Director	Physici /Medio Examir	
To Be Completed by Funeral Director		an cal ier	

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit 10

		For State Registrar	State of h	mai yiailu /		rtificate of L		u Men	Reg.	0.0	0.9	06740	
hysici: /Medic		1. Decedent's Name (First, Middle, Margaret M. Mc						Ι.	Pate of Death Month rch 2,	Day 1	Year	3. Time of Death 10:38A M	
Examin		4a. Facility Name (If not institution, 209 S. Robinso	give street and numbe	r)			Location of De	eath		4c. County of			
ineral rector		5. Social Security Number 219-30-0378 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 🗓 F	Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (/	8. Date of Birth (Month, Day, Year) January 1,1917 Pennsylvania				
f show	tor	10a. State 10b. County		10c. City, Tov					10d. Inside City Limits শু∐Yes 2 □ No				
a or 28a- t be notif	Funeral Director	Md. 10e. Street and Number 209 S. Robinso	n Street		Baltimore 10f. Zip Code 21224				10g	Citizen of Wh	nat Countr	y?	
Department or heatin and wenter trygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ever, if not orbit by notified at once.	<u>ک</u>	11. Marital Status 1 Never Married 2 Marrie 3 Note: Married 2 Married	12. Was Deceder Armed Forces	s?] No	i	Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2X No		(Specify) erto Ricar	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
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n 27 is mark er traumati	To	19a. Informant's Name/Relationshi Wayne Snyo	p (Type. Print)	19	b. Mailir	ng Address (Street a		Rural Rot	ute Number, C	-		Code) MD 2 1224	
tant: If iten jury or oth		20a. Method of Disposition 1 Substitution 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spring)		e cemete	_{ery, crer} don	esition (Name of matory or other place Park	Mar		,2009	Baltin	nore,	Md.	
any in		21. Signature of Funeral Service L	censee	en	22	2. Name and Addres	s of Facility S						
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y the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	☐ Ectopic pregnancy ☐ Other (specify)	,	23d. Date of delivery Month Day Year								
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To the comple		29b. Signature and title of certifier	(.	Y.O.		29c. License	number	71	29d	Date signed (Month, Da	ay, Year)	
10		30. Name and address of person w	N JoHAI	300					. Ba	t, mar	e	21224	
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 5		trar's Signature	1	land							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marlow, Sr. Keeling 28, Anderson February 2009 5:35 a.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Adelphi Hillhaven Nursing Center Hours Min. April 19 Yes If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🙀 M 2 🗆 F 81 422-22-5040 Ohio Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Middeal Examinations once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Greenbelt Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20770 6803 Landon Court Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give WW II Year or Dates: 1 ☐ Never Married 2 🕅 Married 1 ☐Yes 2 🔯 No Specify. Specify: ò Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Veterans Administration Elementary/Secondary (0-12) College (1-4or 5+) Hospital Medical Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Mae Keeling Elijah Marlow ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6803 Landon Ct. Greenbelt, Maryland 20770 Magdalena Marlow (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2009 Greenbelt, Maryland 22. Name and Address of Facility Silver Funeral & Cremation Service Spring, Maryland 20910 M00982 933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 □ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Division of Vital 1 □ Yes 2 🗆 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending thours after death.

Unneral Director: Af 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral t

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only tech 29b. Signature and title of certifier -29c. License number 29d. Date signed (Month, Day, Year) 3×1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Physician /Medical Examiner

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permit. Page Depertment o Importent: If eny injury or once.

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Examiner Physician/Medical Completed by Be

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25. Was case referred to medical examiner?

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27. Manner of Ceath

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

completely

State Registrar

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

male 30. Name and address of person who completed cause podeath (Item 23a) (Type, Print) Gionos

NO

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death Check only one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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31. Date filed (Month, Day, Year) 32. Registrar's Signature

Hospital: 2 ER/Outpatient 3 DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 600 TO DEPARTMENT OF HEARTH AND MENTAL Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** March 2, 2:30 A M Patricia K. Mitchell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2412 Huntwood Court Frederick Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) 6/6/1936 **Funeral** Min. 1 □ M 2 👿 F Months Days Hours 72 Maryland Director 216-34-8699 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be redified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐ Yes 2 No Director Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 2412 Huntwood Court LISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia LeGourd George McFee ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert J. Mitchell, Sr. /Husband 2412 Huntwood Court, Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3/7/2009 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatul of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic obstructive pulmonon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) P.O. I 9 Unknown s been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 2 No 3 Probably 4 Unknown Hyperden sic Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed? certificate Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 ☐ Accident 5 Pending investigation within 24 hours are:
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) the of certifier 29b. Signature and D0051643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Hiren Shah

31. Date filed (Month, Day, Year)

MAR 0 5 2009

32. Registrar's Signature

Thomas Johnson Dr. Frederick, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2009 **Physician** 11:11 PM March 1, Wilma V. Matthews /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Kris Leigh Assisted Living Gambrills If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🗓 F Months Days Hours Yrs. **Illinois Director** 99 Nov 23, 1909 264-29-4380 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, fire Modical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Severn Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7945 Westbury Lane 21144 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify. Specify Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Milton Van Sickle Flov Swee1v 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7945 Westbury Lane Severn, Maryland 21144 Bruce David Matthews/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 3/4/2009 Odenton, Maryland Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licenses Marita Hamor 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and itely filled in by the funeral director, page 2 should he detached to the contract of Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

0

Name and address of person who com

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 March 2, Arthur Nicholson 1:10 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Ellicott City Nursing & Rehab. Cntr Ellicott City Howard Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Hours XX M 2 F Months Days 168-24-1242 10/16/1924 Durham, England Usual Residence of Decedent 10b. County 10c City Town or Location 10d Inside City Limits Maryland Howard Elkridge 1 □Yes 🟋 🖺 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6482 Grommet Drive 21075 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Forman Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Timothy Reed Nicholson Elizabeth Ellen Victoria Dawson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Orminston - Niece 6482 Grommet Drive, Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State Plymoth Meeting, PA. 4 ☐ Donation 5 ☐ Other (Specify) 3/5/2009 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Boulevard, Elkridge, MD. 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA nonetro disease or condition resulting in death) Due to (or as a consequence of). ATHEROSCLEROSIS DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for an a nonneguous offi INSUFFICIENCY Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

by

Completed

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Invition Exercities in ust be notified at

72 hours after

2 should be filed within and Mental Hygiene.

Health tem 27 i

Pages 7 permit. Pages Department of Important: If it any injury or o

Baltimore, Maryland 21215-0036

Box 68760,

o

σ.

Division of Vital Records,

Hospital or Attending

after

24 hours a

within 2.

Director:

Medical

Examine Physician/Medical

certificate be executed burial-transi physician and the attending nse ō detached þ Completed peen page 2 s has certificate Be P this funeral After t Certification: death.

23b. Was decedent pregnant in the past 12 months? 9 Unknown

> autopsy performed 2 No 26. Place of Death (Check only one)

> > 28d. Describe how injury occurred

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

25. Was case referred to medical examiner? 1 Tes 2 Ng 27. Manner of Death

4 Homicide

(Check only one)

29a, Certifier

1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Spore MD

DO033150

MARCH 2009 3

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Shakunmala Gupta, MD, 9650 Santiago Rd., Suite 110, Columbia, MD 21045

31. Date filed (Month, Day, Year)

gistrar's Signature

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** :46 MM 127,2009 Ellsworth Felorucum We /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Utimor If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year Days Min 1 **X**M 2 □ F 80 Director 04 215-22-7201 80 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 □ Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1308 Mosher Street 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ™ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No ģ Specify: 3 Widowed 4 Divorced Black "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Charring Corss Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Janitorial Shipping Compnay Pages 1 and 2 should be filed vent of Health and Mental Hygis int: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carrie Perkins Clinton Newman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Clara Fooks-Sister 7200 Brompton Road, Baltimore, Md 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet3/5/09 Owings Mills, 21. Signature of Funeral Service Licer see 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md H 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Box 68760, resulting in death) Last Due to (or as a conseque Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes tal or Attending Physician: Tis after death.
al Director: After this certificated in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐ No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

X

State Registrar 29b. Signature and title of certifier

of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

4B commonweath AV, catous, ik up

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 **Physician** 2009 ens lain nnie /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Senio Tanor 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months 1 M 2 F Days Hours Min Country 215-34-683 -18-Director 30 Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: I firem 273 is marked other than "natural", or items 23a or 28a-f show any inJury or other traumatic event, it. Wedeal Examine roughts any inJury or other traumatic event, it. Wedeal Examine roughts and 28a-f show 1 √Yes 2 No Director re 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? apt. #258 901 Koaa Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify à Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Joyola College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be lwens ၉ 19a. Informant's Name/Relationship (Type. Print) (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) le 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burjal 2 ☐ Cremation 3 ☐ Removal from State Crematon 4 ☐ Donation S ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bro vas **Physician** acute resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quentially list conditions Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year Day 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 1 🗌 Yes 1 □ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 27, Physician Oneada Louvisa Purdham 2009 7:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Marley Neck Nursing & Rehab. Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07-11-1906 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 21 F 102 Maryland 216-60-7020 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Baltimore 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 21229 United States 3653 Mactavish Avenue or Itams 23a 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 ANo 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status i filed within 72 hours after di I Hygiene. other then "natural", or Itam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: Specify: White 3X XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wesley Rowe Clara Houpt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary Purdham- grandson 3653 Mactavish Avenue, Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ZX Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk. 03-06-09 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 6 8 Kru MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner A pue the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien thed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 ☑ No detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pp 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 1 ☐ Yes 2 No 1 🗌 Inpatient ၉ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! Certification: 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature ad title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2109 D57028 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue #231 Annapolis mp 21401 Ridgely M.D. 600 Aditva Chapra 31. Date filed (Month, Day, Year) State MAR 0 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nend 28b = perfn G889 3/9/09 TT
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** Peters 10:43PM Koderick Julien 03 2009 OL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Raltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 XM 2□ F Months Days Hours 004-14-7818 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notfled at Ba Himone 1 ☐ Yes 2 No MD Pikesville Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21208 500 Koad Upland Pages 1 and 2 should be filed within 72 hours after deathment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 Dives 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothina Managor 12th grade 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peters Emma Abner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Road Pikesville MD 21208 500 Woland Health tem 27 I item 2 20b. Place of Disposition (Name of Garmesone Per ester place) 20c. Location - City or Town, State Owings Mills MD 20a. Method of Disposition 3/9/09° permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 Buriaì 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 03/06/09 Maryland National 22. Name and Address of Facility Vayann C. Greene Funday SVC 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause in each line. MD 21133 Randallstown Approximate Interval Between Onset and Death ome **Physician** disease or condition resulting in death) Uears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year signed by the at a be detached for 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ♣ No 24a. Was an 15C 9 ils certificate has director, page 2 s autopsy performed rronz 1 ☐ Yes 2 KNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{O}}\) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation ours after death.

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filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled i 29a. Certifier 1 🏂 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le 65 65N Charles St. Suite 209 Baltimore and 21204 MD Doberman Dane State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar		State of Ma	ırylanı	d / Depa <i>Cei</i>	artment of F rtificate of I	lealth and l <i>Death</i>	Mental Hy	giene Reg. No.	2009	06750
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		5. Social Security N				ast birthday)		If Under 24 Hrs.	8. Date of Bir	rth	N/A 9. Bir	thplace (State or Foreign
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, it is my cell Expones.		21. Signature of F	5 Other (Spec				Name and Addre	ss of Facility n Society	v of Mar	rvlan	d. Inc.	
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Donna M. Vincenti, MD 31. Date filed (Month, Day State Registrar

32. Registrar's Sig

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 3, 2009

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

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			For State	State of Ma	•	-	ment of He icate of D		·		2000	06750		
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Maryland	shoul nd M mar imat		19a. Informant's Name/Relationship (7)	ype. Print)	19b.	Mailing Ad	ddress (Street an		ural Route Numb		Town, State, Zi	Code)		
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fune of Service Lices	1	DODIT	may make			MMUNITY					
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	3		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type, Print	t) 5	0		-	. 2/			
		•	31. Date filed (Month, Day, Year)	2. Registral	r's Signature	1 Sui	le 200	Kennsto	WN MD	-2	1:36			
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Physician /Medical Examiner

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attending physician for use as the buria

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After this certificate

within 24 hours after death. To the Funeral Director: A

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P.O. Box 68760,

Records,

Division of Vital

Hospital or Attending Physician:

Physician

/Medical

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10a. State

MD

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

altimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Injury or items 23a or 28a-f st important: If item 27 is marked other than "natural", or items 23a or 28a-f st any injury or other traumatic event, Its Medical Evan injury or other traumatic event injury or other event injury or other event injury or

Examiner Physician/Medical Completed 25. Was case referred to medical examiner? Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

perform 1 ∐Yes 2 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 Yes 2. No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

21129

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 Homicide

29a, Certifier

29c. License number D46505

29d. Date signed (Month, Day, Year) NorcH. 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TWANMUH 900 Caton Avenue, Baltimore, MD JUSEPH

State Registrar

Swanne



DHMH 17 Rev 1/2001

15+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 () 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) O3 Month 03 Physician 2009 Street Sr. В. Walter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Catonsville Baltimore Summit Park Nursing Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 217-07-1250 90 Director 29 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evar, and routed by notified at once. Funeral Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21244 5501 Northgreen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 MYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Fork Lift Operator 3rd Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Street P Samuel Street 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5501 Northgreen Road, Baltimore, Md 21244 Bernadine L. Bell-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/9/09 Arbutus, Md 4 Donation 5 DOther (Specify) Arbutus Memorial 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1 Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ase or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) ∃Yes 2 □ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ∐Yes 212 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other:

8:45a.M

VA

10d. Inside City Limits

21215

Approximate Interval Between Onset and Death

400

Year

1 ☐ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 🔲 No

``

1 X Yes 2 ☐ No

Birthplace (State or Foreign Country)

Black

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, Director: filled in by To the Hospital or within 24 hours at To the Funeral D

cal Certification: To Be Completed

4

State Registrar

M ma lino 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

1 ☐ Yes 2 ☑ No

5 Pending

investigation

6 ☐ Could not be determined

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one)

> Urrer Registrar's Signatur

Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

1 □ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 🗆 No

			Pleas . For			delible Ink. Ens artment of Health	•	•	ble. 19 06755
			1 - State Registrar			rtificate of Deatl		Reg. No.	13 00133
	Physici	an	1. Decedent's Name (First, Middle,	Last)			2. Date of I	Death Day	3. Time of Death
· · · · · · · · · · · · · · · · · · ·	/Media		Joseph Edward			1	03-01	-2009	535 P M
	Examir	ier	4a. Facility Name (If not institution, Gillchrist	give street and number)	4b. City, Town, or Location	n of Death	4c. County	
-**	Funeral			6. Sex 7. A	ge (In yrs. last birthday)		er 24 Hrs. 8. Date of E	1	imore 9. Birthplace (State or Foreign
	Director		215-14-8409	1 M 2 □ F	88 Yrs.	Months Days Hours	er 24 Hrs. 8. Date of E Min. 03-05	-1920	Country) MD
70.0	2 >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	neation			10d. Inside City Limits
Mond	f sho	ō	MD Harfor	rd		est Hill			1 ☐ Yes 2 🕅 No
5-0036	r 28a	Funeral Director	10e. Street and Number	Lu	FOLE	10f. Zip Code		10g. Citizen of V	/hat Country?
the second	23a o	al D	501 Forest Val	lley Dr		21050		USA	
200	tems	nner	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic C If Yes, specify Cuban, Mexico	Origin? (Specify Ye's or I	No- 14. Race	e - American Indian, k, White, etc.
36	or i	by F	1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 □Yes 2 🖔 No Specif		Specify	
21215-0036	atural	ted t	15. Decedent's	Year or Dates:	16a, Dece	dent's Usual Occupation		16b. Kind of Bu	WIIICC
215 215	an "n	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	(Give	kind of work done during mo DO NOT use retired)	ost of working		on loos made by
d 2121	ygien er th	Completed	12		Deput	y Sheriff			ore City
and E	even	Be	17. Father's Name (First, Middle, La Joseph Santora	,			her's Name <i>(First, Midd.</i> a tild a Kais		9)
	and Mental Hygies s marked other i	은	19a. Informant's Name/Relationshi		10b Moili				0.1.7.0.1.
⊠	ulth an 27 Is r trau	9 1	Ann Santora (100	ng Address <i>(Street and Num.</i> L Forest Valle		st Hill.	
ialtimore, Maryland	Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place)	Date	20c. Location -	City or Town, State
in a	nent of I		1 Donation 5 ☐ Other (Spe		·	iem. Gardens	03-05-2009	Bel Air,	MD
Balt	Department of Important; If any injury or once.		21. Signature of Funeral Service Li	gensee		2. Name and Address of Faci	liter	Funeral	Home of BelAir
ш а			Mune.	Thad		Inc. 610 W. Ma	acPhail Rd	Bel Air,	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List or	omplications that cause nly one cause on each l	d the death. Do not ent ine.	er the mode of dying, such a	is cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	nysician Medical		Immediate Cause (Final disease or condition resulting in death)	-a. 15CHE	L.M.	DIOMY0 PAR	Ry		Months
	xaminer		1	ATUE O	a consequence of):	Coronar	a Alakon	1) son	se years
1/0	+	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):	C. Oligi	7 111 661	9 11/1564	se gezirs
60, be executed	and transi	Examiner	that initiated events	c					
60,	cian a	1	resulting in death) Last	Due to (or as	a consequence of):				
687 tiflicate	physician and s the burial-transit	dic	8	d					
I Records, P.O. Box 687. The law requires that the death certificate	attending p for use as t	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				23d Date	e of delivery
death	e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	4 🔲 Pregnant a		Ectopic pregnancy Other (specify)		Mor	
at the	by the stached	Phys	9 🗆 Unknown	9 ☐ Unknown					
5 , res th	signed be det		Part II. Other significant condition	s contributing to death t	out not resulting in the ui	nderlying cause given in Part			bute to the cause of death?
ecords, law requires tl	s been sig	eted	1	/ './	5 /		1_	Yes 2 No	3 Probably 4 Unknown
Rec he law	has bge 2 s	Completed by	Chronic K	Gidney	DISEASE	2		opsy p	Vere autopsy findings available rior to completion of cause of
			25. Was case referred to medical				1 □ Yes	2 No 1	eath? □Yes 2□No
	s certific	To Be	examiner?	Hospital:	ent 2 ☐ ER/Outpatier	0.1	ce of Death (Check only Jursing Home 5 Re		want the sice
ot ا gPhy	h. After this funeral dir	Ë	27. Manner of Death	28a. Date of Inju	ury 28b. Time of			how injury occurre	
SIOI Fendir	or: Al	catic	2 Accident investigation	tion		M 1 □Yes 2 □]No		
= 5	# in a	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of In building, e	ury - At home, farm, street. c. (Specify)	eet, factory, office	28f. Location City or To	(Street and Number own, State)	er or Rural Route Number,
L'ipital	24 hours afte le Funeral Dir bletely filled in		29a. Certifier 1 X.Certifving	Physician: To the heet	of my knowledge death	n occurred at the time, date a	and place, and due to the	o called and m-	nnar ac stated
e Hos	Fun Fun	Medical	(Check only 2 Medical Ex	caminer: On the basis of and manner st	of examination and/or in	vestigation, in my opinion, de	eath occurred at the time	e, date and place, a	nd due to the cause(s)
the	thin 2	Me	29h. Signature and title of certifier	3		29c License number		20d Date signed	(Month Day Year)

March 1, 2009 Santora, Joseph To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. Suite 209 Battimore Danielle DoBell 31. Date filed (Month, Day, Year) 2. Registrar's Signiture State MAR 0 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20 PM Year SCHRIEFER ELEANOR 2009 MARCH 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death BAYVIEW MEDICAL CENTE JOHNS HOPKINS BALTIMORE N/A 5. Social Security Number If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🂢 F Months Days Hours Min 213-52-2909 Maryland June-29, 1909 Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1769 Brookview Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify Specify: White 3€Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora Gladtfelter Harry Schriver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Buttrick Court Apt. 302 Timonium Maryland 21093 John Schriefer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 03-04-2009 Towson, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licenses Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Port1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE DRGAN HOURS Due to (or as a consequence of) INFECTION EXTREMIT DWER MENTUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) INFECTION URINARY TRACT DAYS Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

show

23a or 28a-f shoust be notified at

tems

d other than "natural", or Items event, the "edical Evaning"

aith and Mental Hygiene. 27 Is marked other than "r r traumatic event, The Med

Department of Health ar Important: If Item 27 Is any injury or other trau

Director

Funeral

2

Completed

Be ပ္

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Records,

Division of Vital

/Medical

10a. State

Examiner as the ase for detached page 2 should

IF FEMALE:

25. Was case referred to medical examiner?

2 40

5 Pending investigation

6 Could not be

1∐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

sician and burial-transit attending physician Physician/Medical the signed by t t be detach þ Completed peen has certificate director, Be မှ this Certification:

funeral After the

Hospital or Attending death. 24 hours after death Funeral Director: filled in by completely the within 7

State Registrar

Medical

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 1 □Yes 2 □ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

autopsy performed

2 **M**o

1 □ Yes

BALTIMORE

26. Place of Death (Check only one,

29b. Signature and title of certifier

and manner stated.

29c. License number RES - 000

AVENUE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) MARCH 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES 4940 MD EASTERN

31. Date filed (Month, Day, Year) MAR 0 5 2009

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **Physician** 17 200 M.Dorothy Sauer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOLE WASHINGTON MEDICAL ENTER GLEN DUKNIE HRUNDEL . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Year) Min. 1 □ M 2 🛣 F Months Days Hours Director 179-30-5556 71 Feb 5, 1938 Pennsylvania Usual Residence of Decedent 10a State 10c. City, Town or Location show 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar invest be notified at once. Director 1 □Yes 20XNo Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1438 Boulder Lane 21076 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No 2 Specify: Specify: 3 Widowed 4 Divorced White SAUGR, DOBOTHY Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Joseph Bombay Stella Scovich 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerold A. Sauer/husband 1438 Boulder Lane Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 3/3/2009 Odenton, Maryland 21. Sign wife of Funeral Service Lice 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. Morney M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of) P.O. Box 68760, the attending physician the for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown sign**e**d | d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Division of Vital I□Yes 2 □N6 2 - No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **3** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifies 29c. License number

State

Registrar

30. Name and address of person

led (Month, Day, Year

MAR 0 5 2009

ALTMORE

DHMH 17 Rev 1/2001

WATUITGION

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

MEDICAL CLANIUS

			For State Registrar	State o	of Marylar		artment of F rtificate of			•	giene Reg. No. 2 N	ηq	06758
	Physici		1. Decedent's Name (First, Middle Kenneth K. Ta							2. Date of De Month	ath Day	Year	3. Time of Death 5:30 PM
***	/Medi Examir		4a. Facility Name (If not institution 11308 Mitscher	n, give street and nu	ımber)		4b. City, Town, o			FEB	4c. County		3.30 1
	Funeral Director		5. Social Security Number 576–10–8305	6. Sex 1 M 2 ☐ F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sept •	Montgo th 26,1920	9. Birthp Coun Haw	ace (State or Foreign try) aii
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Mont	gomery	10c. C	ity, Town or Lo	cation Kensing	ton					0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 11308 Mitsche	er St.			10f. Zip Code	2089	5		10g. Citizen of W United		/ -
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarrine must be notified at once.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed Fo	2 🗆 No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2ሺNo	lispanic Ori an, Mexicar Specify:	n, Puerto R	cify Yes or No lican, etc.)	Blac	e - Americ k, White, e . Asi	tc.
21215-0036	within 72 ho jiene. r than "natu l	Completed by	15. Deceden (Specify only highes Elementary/Secondary (0-12)	t's Education t grade completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	t of working	´	16b. Kind of Bu NIH / Nat'l In		ustry ute of Hlth
yland 2	ould be filed Mental Hyg arked other atic event, I	To Be C	17. Father's Name (First, Middle, Yutaro	*	emoto			Su	mi	(First, Middle,	Maiden Surnam Hiro	naka	
Baltimore, Maryland	s 1 and 2 sho f Health and fem 27 is m other traum		19a. Informant's Name/Relations Alice Takemoto 20a. Method of Disposition		20b.	11308	ng Address (Street B Mitsche sition (Name of	r St.		singto		2095	·
altimo	mit. Pages partment o portant; If i r injury or	i i	1 ☐ Burial 2 🏻 Cremation 4 ☐ Donation 5 ☐ Other (S ₁ 21. Signature of Funetar Service	pecify)	State	esapeak	natory or other place ce Cremate Name and Addres	ory	v		Beltsv	ville	
Ã	permi Depar Impor any ir		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	NOORS:	X 9	Rapp Fune 033 Gist er the mode of dyir	Ave.,	Silv	er Spr	ing, MD	20	910 Approximate
5	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	Advance		eimer's D	iseas	e				Interval Between Onset and Death
68760,	ficate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec		-						
O. Box	Physician: The law requires that the death certificat this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregn birth 2 Feta nant at time of nown	al death 3	Ectopic pregnance Other (specify)	у			23d. Date Mor	e of delive	y Day Year
rds, P.	w requires that s been signed b should be deta	ò	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the ur	nderlying cause give	en in Part I.		23e. Did to			e cause of death?
tal Records,	sician: The law re certificate has ber irector, page 2 sho	• Completed	25. Was case referred to medical							1 □Yes	med? d 2√2 No 1	Vere autop rior to com eath? □Yes	sy findings available pletion of cause of
Division of Vital	To the Hospital or Attending Physicis within 24 hours after death. To the Funeral Circators After this cer completely filled in by the funeral direct	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determine	28a. Date (Mon ation of be 28e. Place	th, Day, Year)	28b. Time of Injury	28c. Injun Work	er: 4 □ Nu vat	rsing Home 28	d. Describe h	lence 6 Other	d	
•	Hospital 24 hours a Euneral Cletely filled	Medical Ce	29a. Certifier 1 Certifyin (Check only one) 2 Medical I	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina ner stated.	owledge, death ation and/or inv	occurred at the tir vestigation, in my o	ne, date an pinion, dea	d place, ar th occurred	nd due to the	cause(s) and mar date and place, a	nner as st nd due to	ated. the cause(s)
	To the within complete	Me	29b. Signature and title of certifier All 30. Name and address of person of	ingall	1,15	n 23a) (Tvpe. I		number		2	29d. Date signed March 3		
	Sta Registr	_	Phillip Poth M 31. Date filed (Month, Day, Year) MAR 0 5 2009	.D. 871		ood Ave	., Silver	Spri	ing, l	MD 209	910		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Dav **Physician** Virginia Thias March 4, 2009 2:46AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Heartlands of Severna Park Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 15, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 K) F 192-18-2287 1922 Director Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No Director SC Spartanburg Spartanburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number a or 513 W. Calhoun Crossing Court 29307 U.S.A. r than "natural", or items 23a the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 should be filed w h and Mental Hygier 7 is marked other th Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Schramm Frances 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Mrs Francine Cavill/Daughter 6603 Greenvale Court Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 5 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Atlantic Crematory 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service kicensee Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ereprovas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (ur as a consequence ut) Examiner burial-transi Due to (or as a consequence of): Physician/Medical the as IF FEMALE: use a 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Ves 2 2 No 25. Was case referred to medical examiner? Assisted Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 ☐ Yes 2 ER/Outpatient 3□ D0A P 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 atural Injury

Box 68760 pe P.0. Division or Vital Records,

72 hours after

3altimore, Maryland 21215-0036

physician signed by t certificate funeral director, this After ...al or Ah.
Ours after deab.
I Director: Ah.
in by the fire

within 24 hours at To the Funeral D the

Medical

29b. Signature and title of pertifier

and manner stated.

6 ☐ Could not be

determined

50725

rars Hwy Millersville

1 ☐ Yes 2 ☐ No

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (1

Accident 3☐ Suicide

4 Homicide

(Check only one)

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	For State Registrar		State of M	•	PHYS G889 epartment of Certificate of		vientai Hy	/giene Reg. No.	2009	0676
ian	Decedent's Nam MARY	ne (First, Midda	le, Last)		TURNER		2. Date of D Month	eath Day	Year 2009	3. Time of Death 2129
ical iner	4a. Facility Name (n, give street and number, AL HOSPITAL)	4b. City, Town,	or Location of Death			County of Death	h
	5. Social Security I 217-74-1		- 6 44	ge (In yrs. last birti	hday) If Under 1 Year Months Days		8. Date of B	irth 1932	9. Birth Con	hplace (State or Forei untry)
	Usual Residence of	of Decedent	1	10c. City, Town	or Location					10d. Inside City Limi
ctor	MD	BAL	TIMORE	RO	SEDALE					1 ≝ Yes 2□N
Director	10e. Street and Nu				10f. Zip Code			10g. Citiz	en of What Co	untry?
Funeral	2032 I	LINTSH	12. Was Deceden	t Ever in U.S.		237 Hispanic Origin? (St	pecify Yes or N	lo- 1	USA 4. Race - Amer	rican Indian,
듄	1 Never Mar	ried 2□ Mar	Armed Forces	?	13. Was Decedent of If Yes, specify Cu		o Rican, etc.)		Black, White	
þ	3 Widowed	4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🔼 No	Specify:		1 5	Specify: BI	ACK
Completed	(Spe		nt's Education	16a.	Decedent's Usual Occu	upation e during most of wor	kina	16b. Kin	d of Business/I	Industry
app.	Elementary/Sec	, , ,	College (1-4or		(Give kind of work done life. DO NOT use retire NEVER WORK)		9			
ဝ	17. Father's Name	(Eiret Middle	(set)		MEVER WORK	18. Mother's Nam	ne (First Middl	a Maiden 9	Surnamal	
Be		·					BAYON	o, musuon c	ourname)	
P	19a, Informant's N	FAGGIN Name/Relations	·	19b.	Mailing Address (Stree			ber, City or	Town, State, Z	(ip Code)
			RICK/DAUGHTE	- 1		NTSHIRE R		-		E, MD 2123
1	20a. Method of Dis	,		comotor	Disposition (Name of y, crematory or other pl	lace)	Date	20c. Loc	ation - City or	Town, State
		Cremation ☐ 5 ☐ Other (5	3 □Removal from State Specify)	MT. Z			9/09	BALT	IMORE,	MD
	21. Signature of F	uneral Service	Licensee		22. Name and Addi	ress of Facility JA				
	as	nes (a. Wforter	n	1701 LAUR					
ical Examiner	resulting in death) Sequentially list of any leading to it any leading to it cause. Enter Und Cause (Disease o that initiated event resulting in death)	onditions, immediate lerlying - r injury ts	b. Due to (ure)	s a consequence of	ŋ:	7 Orsees				
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۵	Part II. Other sign	ificant condit	ions contributing to death	but not resulting in	the underlying cause g	given in Part I.				the cause of death?
Completed	<u> </u>						24a. Wa aut per 1∐ Yes	opsy formed?		topsy findings availa completion of cause of
Be (25. Was case refe examiner?	erred to medica			Ta	26. Place of Dea	th (Check only	one)		
P		≱ √No	Hospital: 1 Inpat		patient 3 DOA				Other (Spec	cify)
	27. Man of Dea 1 Natural	5 Pendi	28a. Date of Inj		njury Wo	ury at ork? □Yes 2□No	28d. Describe	how injury	occurred	
ion:	2 Accident	IIIVESL	igation not be	njury - At home, far	m, street, factory, office		28f. Location City or To	(Street and own, State)	l Number or Ru	ıral Route Number,
ertification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	nined 28e. Place of in	etc. (Specify)						
Certification:		deterr	nined 28e. Place of in	t of my knowledge	, death occurred at the d/or investigation, in my	time, date and place opinion, death occu	, and due to th irred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s)
Medical Certification:	4 ☐ Homicide 29a. Certifier (Check only	1 Certifyi 2 Medica	ing Physician: To the best Examiner: On the basis and manner s	t of my knowledge	d/or investigation, in my	time, date and place y opinion, death occurse number	a, and due to the	e, date and	and manner as place, and due signed (Month	to the cause(s)
edical Certification:	4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signature an	deterr Certifyi	ing Physician: To the best Examiner: On the basis and manner s	t of my knowledge of examination and stated.	d/or investigation, in my 29c. Licer	opinion, death occu	a, and due to the time	e, date and	place, and due	to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 11:10 AM ROBERT URSCHEL FEBRUARY 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SIMANB USJO BALTIMORE - WASHINGTON MEDICAL CENTER JEOUWSA UULA If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days **1X** X M 2 □ F 09-06-1924 Ohio 294-22-6606 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy liupry or other traumatic event, the Medical Examinat must be rotified at once. 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 □Yes 2√TNo Severna Park MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 445 Maryleborn Road 21146 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes **2**(X)No Specify. <u>Ş</u> Specify: 3KWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) District Manager Insurance Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Jacob M. Urschel Stella M. Spurgeon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Keyser- Daughter 445 Maryleborn Road, Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 03-02-09 Atlantic Crematory Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Nauk M. Su 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** 2 DAYS AIHOMUZUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gauss (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 5 Other (specify) Division of Vital Records, P.O. sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRICIATION 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending after death.

I Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a

To the Funeral I

completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Direction des Composition D0065314 FEBRUARY 28, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO DOSÉ GIANGRECO 301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar MAR 0 5 2009

ilberto Garcia Varanez Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 06762 **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day March 1, 2009 Garcia **Medical Examiner** Gilberto 0430 hrs Vazquez 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Route # 32 North of Linden Church Road Clarksville Howard If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director 1 XM 2 F 26 Yrs June 8. Mexico Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No 28a-f show MD Carroll notified at once Westminster irector 10e. Street and Number 10g, Citizen of What Country 10f. Zip Code 528 Goldenroad Terrace 靣 21157 Mexico 238 Funeral 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, must be Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No è after Divorced Yes, Give Year 1 X Yes 2 No specify: Widowed Specify: Mexican "natural" other traumatic event, the Medical Examiner ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.

ant: If item 27 is marked other than ", MD 21215-0036 Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roberto Garcia Ortega Be Virginia Vazquez Jimenez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Cousin) Mr. Cesar Castillo Villavicencio 20248 Shipley Terrace Apt. 101, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State Itimore, El fematory or other place) El fanteon Municipal de Santiago Tejocotillos 1 X Burial 2 Cremation 3 X Removal from State 3/12/2009 rtment c Xonacatlan, Mexico Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PO Box 195 Sykesville, MD 21784 Haight Funeral Home & Chapel, PA, Haight MO0764 Vilan L. 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Mulitple Blunt Force Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day Year past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the a g Unknown о. О. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? page certificate ✓ Yes 2 No ✓ Yes 2 No : After this certifications : Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other₄ Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene 2 1 V Yes 28a. Date of Injury (Month, Day, Year) Mar 1, 2009 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Passenger auto auto collision 0357 hrs Natural 5 Pending Yes 2 V No Funeral Director: stely filled in by the 2 🗸 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 32 North of Linden Church Road, Clarksville, Md. determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 1, 2009 and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 32. Registrar's Sig

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

		1 - For State Registrar	State of N	Maryland	i / Depa <i>Cei</i>	artment of I rtificate of	Health a	and M		gienez () (9 0	6763
Physic /Med		1. Decedent's Name (First, Middle Raymond	e, Last) J. Woerne	er					2. Date of Dea Month	Day	Year	Time of Death 750A M
Exam		4a. Facility Name (If not institutio		er)		4b. City, Town, o				4c. County of		
Eupora		Seasons Ho 5. Social Security Number		Age (In yrs. la:	st birthday)	Rand If Under 1 Year	alls	24 Hrs.	8. Date of Birt	th	9. Birthplace	Ore (State or Foreign
Funera Directo		220-18-9187	X IXM 2□ F	81	Yrs.	Months Days	Hours	Min.	(Month, Da	, 1927	Country) Mary	
w w		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					10d In	nside City Limits
Maryla f sho ied at	Ď		timore			11stown						□Yes X I X No
r 28a	Director	10e. Street and Number	OIMOIC		- Carrota	10f. Zip Code	-			10g. Citizen of W	hat Country?	
th with	la D	8924 A 11 en	swood Rd.			21	133			U.S	.A.	
DESILLIMOFE, IMBRY/ISING Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Marical Expininer must be notified at mone.	y Funeral	11, Marital Status 1 Never Married XX Mar		9	13.	Was Decedent of H fYes, specify Cub I □Yes 🏋ズNo	Hispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Inc , White, etc. Whit	
Z 1 5-UU36 hin 72 hours aft e. an "natural", or Medical Exami	ed by	3 Widowed 4 Divorced		s: WW 11		dent's Usual Occur						
in 72 n "nai	plete	(Specify only highe	nt's Education st grade completed)		(Give	kind of work done OO NOT use retire	during mos	t of workii	ng	16b. Kind of Bus	iness/industry	
d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-4d	JI 5+)	CP.	A	,			Accoun	ting	
Waryland 2121 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than " traumatic event, Iro Mar	Be	17. Father's Name (First, Middle,	Last)						, , ,	Maiden Surname	,	
yla lould I d Men narke	ဥ	Raymond Woe							1	Charch		
Mal d2st tth and tth and traur		19a. Informant's Name/Relations Virginia L. W		fo		,				er, City or Town, S . 1stown		*
Fe, and Heal		20a. Method of Disposition	voermer/wi						ate	20c. Location - C		
Daltimor permit. Pages Department of mportant: If its iny Injury or o		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Qther (S		te Mea	adowr	sition (Name of natory or other place idge ial Par	le !	3/6/	′ 09	E1krid	ge, M	D
ralti.		21. Signature of Limer Service			22	. Name and Addre	ess of Facilit			Funera		
0 80E 6		Thehad	/mm		`							MD2111
Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that cause only one cause on each	sed the death. In line.	10	er the mode of dyi	ng, such as	cardiac c	or respiratory ar	rrest,	Appr Inter Onse	roximate val Between et and Death
/Medical Examiner	1	resulting in death) Sequentially list conditions	b. End	as a conseque Starge	ende of): e Chi		bst	ruci	tive Pu	Umona	N	
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consule	ence of):				50		/	
execunand and ial-tra	Exar	that initiated events resulting in death) Last	c. <u>U/364</u> Due to (or a	as a conseque	nce of):							
cate be executed ohysician and the burial-transit	dical		d									
entifica ing ph	Med	IF FEMALE:										
death cer attendir	Physician/Med	23b. Was decedent pregnant in the past 12 months?	4 ☐ Pregnan	h 2□ Fetal d at at time of dea	death 3	Ectopic pregnand Other (specify) _	у			23d. Date Mon	of delivery th Day	Year
by the	hys	9 Unknown	9 🗆 Unknow	n					_			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	þ	Part II. Other significant condition	ons contributing to death	n but not result	ing in the ur	nderlying cause giv	en in Part I.			obacco use contril ⁄es 2 ☐ No 3	oute to the cau	use of death?
law re as be 2 sho	Completed								24a. Was a		ere autopsy fir	ndings available ion of cause of
The cate h	5								perfoi	rmed? de	ath? ⊐Yes 2.⊠N	
VILAI iician: T certificat ector, pa	Be	25. Was case referred to medical examiner?	Hospital:			t all post Oth			(Check only o		La Sava	· Clfacolli
Phys	l E	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpa	atient 2 El	R/Outpatien 28b. Time of	I 3 L DOA	4 LJ Nu			dence 6 QOther		
Attending Phy r death. ector: After thic by the funeral c	ţi	1 Natural 5 ☐ Pendin 2 ☐ Accident investi	ig (Month, i	Day, Year)	Injury	28c. Inju Wor M 1	kí? ∐Yes 2 ∐ l		ou. December	iow injury occurre		
or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inal I 286. Place of	Injury - At hom etc. (Specify)	ne, farm, stre	eet, factory, office		2	28f. Location (S City or Tow	Street and Number vn, State)	or Rural Rout	te Number,
Hospital Hospital Puneral I	edical Ce	29a. Certifier 11 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis	s of examination	ledge, death	occurred at the ti	me, date ar	nd place, a	and due to the ed at the time,	cause(s) and mar date and place, ar	nner as stated.	cause(s)
fo the vithin of the comple	Med	29b. Signature and title of certifie	and manner	Signou.		29c. Licens	e number			29d. Date signed	(Month, Day,	Year)
->-0		relebrah	& Burl	n po		1449	931			March	1.	7009
10+1		30. Name and address of person	who completed cause o	of death (Item 2	23a) (Type, I			= S1A	TF. 705	BAZTII	uon E	MD
SI	tate	31. Date filed (Month, Day, Year)	7. Regi	strar's Signa	re			201		2		
Regis		MAR 05	ZUUY KRAM	a p.	17	-71474						·

DHMH 17 Rev 1/2001

			For State	State of	f Marylan		artment of He ctificate of D		lental Hy	giene _{Reg. No} 2 (119	06764
			Registrar 1. Decedent's Name (First, Middle,	Last)		001	tineate of b	- Cuir	2. Date of Dea	ath		3. Time of Death
	nysicia Medic		Patrick	Wils	on				March March	4 Day	200 ^{ye ar}	2:00 A M
The same of the sa	xamin		4a. Facility Name (If not institution, 10106 Wesleigh Driv	-	nber)		4b. City, Town, or I	ocation of Death		4c. Cour	nty of Death Howard	
Fu	neral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bird	th V Year)		place (State or Foreign ntry)
	ector		552-94-3772	1 X M 2□ F	5	5 Yrs.	Months Days	Hours Min.	December	3,1953	Mary]	and
land	til		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
Mary	illind	ctor	Maryland Howard			(Columbia					1 ☐ Yes 2xxx No
ith the	2 20	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen		ntry?
eath w	1811	Funeral Director	10106 Wesleigh Dr		edent Ever in U	.s. 13. \	Vas Decedent of His f Yes, specify Cubar		ecify Yes or No		.S.A.	can Indian,
after d	- ifrar	Fur	1 Never Married 2 Marrie	Armed Fo	rces? 2 ☑ No	Ī	fYes, specify Cubar 1 □Yes 2 □ No	, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
DOOD TO "Israel" or	I Evn	d by	3 Widowed 4 Divorced	Year or D	ates:		dent's Usual Occupa			Spe	Business/In	ite
in 72 h	Audio	Completed	15. Decedent's (Specify only highest	grade completed)	Ann F. \	(Give	kind of work done di OO NOT use retired)	uring most of work	ing	TOD. KING O	D0381633/1	iddstr y
d with	1	Som	Elementary/Secondary (0-12)	College (1	-40r 5+)	Roo	ofer			U.S.D.		
VIAITO VIII De file Mental Hy	event	Be	17. Father's Name (First, Middle, L	*				18. Mother's Nam			iame)	
thould he	matic	욘	Charles G. Wilson 19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a		ee Fitzpa ral Route Numb		vn, State, Zi	p Code)
nd 2 salth ar	er trau		Wendy Strawhorn	(Neice)		1	Golden Cres					, , , , , , , , , , , , , , , , , , ,
pairtimore, Maryliatid ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylgiene. Incorporate it should not be also "Apply and "patients" or items 32a or 28a.5 show	or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □ Bemoval from	20b. I	Place of Dispo cemetery, cren	sition (Name of natory or other place)	Date	20c. Locatio	n - City or T	own, State
Dallimore Dermit. Pages 1:	njury o		4 □ Donation 5 □ Other (Sp	ecify)	At]	lantic Ci		3-5-2		Glen Bu	rnie, M	aryland
permi Depa	any ii		21. Signature of Juneral Service L	Icensee		W.	Name and Address itzke Funera 555 Twin Kno	il Homes, I	nc. Columbia	Marvl:	and 210	45
			23a. Part 1. Enter the disease, or o shock, or heart failure. List of	complications that o	aused the deal						nid 210	Approximate Interval Between
Physi	ician		Immediate Cause (Final disease or condition			Small (Cell Lung Ca	ncer				Onset and Death 5 Months
/Med Exam	dícal niner		resulting in death)		or as a consec	quence of):						1 V
100	1	ē	Sequentially list conditions,	b	OPD or as a conse	wence of :						1 Year
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ficate be executed	priystoral and s the burial-transit	a E	resulting in death) Last	Due to	or as a consec	quence of):						
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The law requires that the death certif	nas been signed by the attending let 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		☐ Ectopic pregnancy			23d.	Date of deliv	
ne dea	ne an	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of		Other (specify)				MOTH	Day Year
that th	detac		Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
ecords, law requires t	uld be	ed by	Non Hodgkins L	ymphoma					1 💢	Yes 2 □ No	o 3□ Pro	bably 4 Unknown
law re	as ne	Completed							24a. Was	psy	prior to co	opsy findings available ompletion of cause of
a : The :	r, page								1 □ Yes		death? 1 ☐ Yes	2 🗆 No
OT VITAL Physician: T	Aner uns cermicate n funeral director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	1 ER/Outpatier	nt 3 DOA Othe	26. Place of Dear	th <i>(Check only c</i> ome 5 ⊠ Resi		Other (Snec	ifv)
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SION tending leath.	the fur	catic	2 Accident investig.	ation			M 1 1	res 2□No	204 Landian	Ot 1 1 M		T. Bouts Months
DIVI	d in by	Certification:	4 Homicide determi	nod Zoe. Flace	ing, etc. (Spec	ify)	eet, factory, office		City or To		imber or Hui	al Route Number,
To the Hospital or Attending P within 24 hours after death.	runeral tely filled	Medical C	29a. Certifier (Check only one) Certifying Certifying Certifying	Examiner: On the b	e best of my kn casis of examin	owledge, deat ation and/or ir	h occurred at the tim	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
Fo the within 2	o me	Mec	29b. Signature and title of certifier	270	nier stated.		29c. License	number		29d. Date sig	gned (Month	, Day, Year)
			> Edwar	l the	emp		D236	01		Marc	ch 4, 20	009
	6		30. Name and address of person v Edward J. Lee, M.	D. 11065 L	ittle Pat	tuxent Pa	arkway Colu	mbia, Mary	land 2104	14		
R	Sta Registi		31. Date filed (Month, Day, Year)	009	Registrar's Sign	ature	de					

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Williams-Lewis Jeanette 2009 Pearl 0.3 02 5:15p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3611 Hicks Ave Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 0 3 20 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔽 35 73 MD Director 215-28-3023 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Medical Exactine must be notified at 1 XYes 2 □ No Director Baltimore NA MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ò 21207 U.S.A. 23a 3611 Hicks Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 □Yes 2 No If Yes, Give X Year or Dates: 1 □ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black \$ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) than Director Of Personnel TIMBO marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item Z7 is marked othr any injury or other traumetin 17. Father's Name (First, Middle, Last) Be Pearl E. Lyles John S. Gordon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 Harold Lewis-Husband 3611 Hicks Ave, Baltimore, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arbutus Memorial 3/7/09 Arbutus, Md 21. Signaline of Funeral Service Licensee March F/H West 4300 Wabash Ave, 21215 Baltimore, Mi Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate 23a Part1 Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1002.450 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No P.0. the 9 Unknown 9 Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performe certificate 1 □Yes 2 □No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **A**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the Hosp within 24 hou To the Fune completely fi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar Signal State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** Walker 5:10a Jacqueline /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Stella Maris Hospice 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Months 1 □ M 2 ₽ F Director 14 48 215-80-7482 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 √Yes 2 No Director MD NΑ Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 U.S.A. 2322 West Lanvale Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 XYes 2 ☐
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify <u>ک</u> Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Medical Claims Processor Total Health Care is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Lonnie B. Walker Charles Cooks Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mportant: If item 27 i 1508 King William Dr., Catonsville, Dorothy Reed-Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Park 3/9/09 Woodlawn, Memorial 22. Name and Address of Facility
March F/H West Signature of Funeral Service Licensee Yen 21215 4300 Wabash Ave, Baltimore, Md 3a. Part1 Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shork, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate Cause (Final discusses or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): P.O. Box 68760. requires that the death certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) □Yes 2XNo the 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ģ 2X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s perform 2 X No 1 ☐ Yes of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Euneral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou

To the Fune

completely fi (Check only 2 Medical Examiner: On the basis of examiner Nurse Practition Parener stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie erson who completed cause of death (Item 23a) (Type, Print) CRNP 2300 DULANEY JONES, JACKĪE VALLEY RD. TIMONIUM, MD 21093 State Registrar

DHMH 17 Rev 1/2001

JACOUELINE WALKER

Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💆 F 90 302-09-8456 Yrs 11/03/1918 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show Prince George's permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D_partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment in the notified at other. Director Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 3251 Gracefield Rd. #401 20904-Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? ☐Yes 2 No 1 ∐Yes 2
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zina Jacob Yeiter Altona May Robison ٩ 19b3 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walter G. Wells/Husband 3251 Gracefield Rd. #401 Silver Spring, MD 20904-Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crematory 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility m00382 Stiple & Lothermann Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed 24a. Was an autopsy perform 1 ☐ Yes 2 Z No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation illed in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours after To the Funeral Direct

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

Day

3,

Specify:

2. Date of Death

March

For State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Luella Y. Wells

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 10b & e. & 19b, per Fh g889 3/20/09 TT

State of Maryland / Department of Health and Mental Hygiene 3. Time of Death Year 2:29 PM 2009 4c. County of Death Montgomery Birthplace (State or Foreign Country) OH 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian. White 16b. Kind of Business/Industry Public Education 20c. Location - City or Town, State Beltsville, Maryland Approximate Interval Between Onset and Death Hours 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 29a. Certifier

29b. Signature a

(Check only one)

TARKHURST

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110

32. Registrar's Signature

Medical

State

GRACEFIELD

29c. License number

SILVER SPRING

State of Maryland / Department of Health and Mental Hygiene 2009 1 - State Registrar 06768 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** 4:00 PM Mildred Pear1 Walders tebruary 28 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Montgomery Olna HOSPITA (Teneral | If Under 14 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. | 19,1915 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕏 F 93 219-68-3174 Director Arkansas Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r items 23a or 28a-f show MD Rockville 1 ☐ Yes 2 No Montgomery Director with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10401 Grosvenor Place United States Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Heatlh and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ary or other traumatic event, the Medical Examinates Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Zalie Mariot Grover Bates ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 5225 Pooks Hill Rd #1203S, Bethesda, MD 20814-2021 Vaile Walders / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 3/5/09 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave., Silver Spring, MD MC0382 21. Signature of Funeral Service Ligens Cremation Services 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Asperation prumenio /Medical Due to (or as Monsequence of): **Examiner** dillicite Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manmer of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 54996 28, 2009 rebruary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Prince Philip De. Dichhuona Olney, Md inh 18101 31. Date filed (Month, Day, Year 2. Registrar's Sign State MAR 0 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2009 g 00:8 BERNARD R. WILLIAMS 24 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ROSEDALE BALTIMORE MANOR CARE-RIDGE RD. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Months Days Hours XXM 2 F 88 Yrs. March 12 1920 MARYLAND 215-12-1682 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No BALTIMORE CO WHITE MARSH MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 348 LORLEY ROAD 21162 .S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) RAILROAD/SPARROWS College (1-4or 5+) Elementary/Secondary (0-12) TRACKMAN POINT 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS WILLIAMS MARIA WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)

1400 Rustic Avenue, Baltimore, Maryland 21237

20c. Location - City or Town, State

29d. Date signed (Month. Dav. Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f

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"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumattc event, the Medical.

Examiner must be notifled at

Director

Funeral

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Completed

Be

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Naomi Cook/Daughter

20a Method of Disposition

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

azar

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner attending physician for use as the buria by Physician/Medical ed by the signed by t Be Completed page 2 s Medical Certification: To within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760.

1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ASBURY U.M		03-02-0	O WHI	тт марс	H, MARYLAND
21. Signature of Funetal Ervis Junior Lands	22. Na WIL	ame and Address of F	acility WN COMM	FUNERAL	номе-на	RFORD, P.A.
23a. Part1. Enter the decase, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	the death. Do not enter th		h as cardiac or res			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): consequence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 24 □ Pregnant at 39 □ Unknown	2 ☐ Fetal death 3 ☐ Ec	topic pregnancy her (specify)			23d. Date of de Month	olivery Day Year
Part II. Other significant conditions contributing to death bu	t not resulting in the unde	rlying cause given in F	Part I.	-	use contribute t !□ No 3 □ F	o the cause of death? Probably 4 Donknown
				24a. Was an autopsy performed? 1□ Yes 2☑N	prior to death?	utopsy findings available completion of cause of s 2 \square No
25. Was case referred to medical examiner?			Place of Death (Ch	neck only one)		
1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatient	3□ DOA Other: 4[Nursing Home	5 Residence	6 □Other (Sp	ecify)
27. Manuar of Death 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	y 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		Describe how inju	iry occurred	
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inju building, etc	ry - At home, farm, street, . (Specify)	factory, office	28f.	Location (Street a City or Town, Stat	nd Number or F e)	Rural Route Number,
29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or inves					

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Registrar 29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	ıryıarıu		ertificate of			ıtaı Hyg	giene Reg. No. 1	200	9	06770
	Dhunini		1. Decedent's Name (F		st)						Date of Dea			ar	3. Time of Death
	Physici /Medio		NORMAI	N	M. 2	ZELLI	ER				EBRUAR	2Y 2		09	14:30 PM
	Examir	er	4a. Facility Name (If no					4b. City, Town,	or Location	of Death		4c. (County of D	eath	
			JOHNS HOPKIN 5. Social Security Num			CEN (In yrs. la.		BALT I	MORE	r 24 Hrs. 8.	Date of Birt	h	9	Birthola	ice (State or Foreign
	Funeral Director			1	⊠ M 2□ F	48	Yrs.	Months Days		Min.	Date of Birt (Month, Da			Countr	y)
	ъ		214-80-80 Usual Residence of De	ecedent							<u> </u>	7/19	61 M		
	arylan show	_	10a. State	0b. County		10c. City,	Town or	Location						100	d. Inside City Limits 1 □ Yes 2 ☑ No
	Ba-f s	Director	MD	Baltim	ore	Dur	ndalk								T T
	death with the Maryland ims 23a or 28a-f show		10e. Street and Number	er				10f. Zip Code				10g. Citiz	zen of What	t Countr	y?
	eath 1s 23	Funeral	7831 St. 11. Marital Status	Gregory	Drive 12. Was Decedent B	ver in U.S.	1:	21222 3 Was Decedent of		rigin? (Specify	Yes or No	USA	4. Race - A	America	n Indian
(0	r iten	Fur	1 Never Married	2 Married	Armed Forces? 1 X Yes 2 □ N	lo		3. Was Decedent of If Yes, specify Cub			an, etc.)		Black, W		
03	hours after tural", or ite	by	3 ☐ Widowed 4	Divorced	If Yes, Give Year or Dates:	181		1 □ Yes 2 💢 No	Specify	y:			Specify:	Whit	e
5-0	72 hc 'natur	etec	15 (Specify	5. Decedent's Ed only highest gra	lucation ide completed)		(Gi	cedent's Usual Occu ve kind of work done	durina mo	st of working		16b. Kin	nd of Busine	ess/Indu	stry
21215-0036	within iene. than "	Completed	Elementary/Seconda	ary (0-12)	College (1-4or 5	+)	life	p. DO NOT use retire	ed)	_		Bui	lding	g Co	nstruction
1/2	filed v Hygie other i		17. Father's Name (Fir	st, Middle, Last))		Car	penter	18. Moth	her's Name (Fi	rst, Middle,	Maiden S	Surname)		
and	d be ental ked o	To Be	Norman M.	•						,	Seajac		,		
2 Z	should and Mer marke umatic	-	19a. Informant's Name				19b. Ma	ailing Address (Stree					Town, Sta	te, Zip C	Code)
2,≥	and 2 ealth a n 27 is		Eleanor Z	eller/Mo	ther		78:	31 St. Gre	egory	Drive	Dunda	lk,	MD 21	222	
ore	of He		20a. Method of Dispos		Removal from State	20b. Pla	ace of Dis metery, c	position (Name of rematory or other pla	ice)	Date		20c. Loc	cation - City	or Tow	n, State
altimore, Mar	Page ment ant: If		4 □ Donation 5			Che	esape	eake Crema	atory		eb 28 009	Bel	tsvill	le, 1	Maryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmortant: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once.		21. Signature of Fune	ral Service Licer	isee M	0144	3	22. Name and Addr Cremation		,	71+or	nn+i-			
_	40 = # O		ayund	a Xu	2 Willia	Al Al-	Dante	8717 Gree	n Pas	tures Dr	ive :	Balti		Max	vland 21286
		3 1)	23a. Part1. Enter the shock, or heart f Immediate Cause (Fir	ailure. List only	one cause on each lin	e.				is cardiac or re	spiratory ar	rrest,		1	pproximate nterval Between Onset and Death
4	Physician /Medical		disease or condition resulting in death)	iai	a. MULTIPI Due to (or as a			FAILUR	E					-	
	Examiner				b. PCLYMI	Marin Asia	ation 1	BACTERE	YT A	AND PA	le un	nt Ti	2		
	. 7	Jer	Sequentially list condit if any, leading to Imme cause. Enter Underlyi Cause (Disease or injuthat initiated events	tions, ediate	b. Due to (or as a			DITO 10101	1991	APP II	Curo	14-1-		1	
191	ocuted ind transi	Examiner	Cause (Disease or injuthat initiated events	iry	c. END-SI			ER FAILU	RE					4	
68760.	tificate be executed g physician and as the burial-transit		resulting in death) Las		Due to (or as a		,								
87	tificate ig physi as the b	edical		•	d. ETOH	ABUS	E								
	certifi nding ise as		IF FEMALE:		23c. If yes, outcome	of pregnan	су					2	3d. Date of	deliver	
Box	e law requires that the death cer has been signed by the attendin to 2 should be detached for use	Physician/N	23b. Was decedent pr in the past 12 mo 1 ☐ Yes 2 ☐ N	onths?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal of	death :	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			-	Month		y Day Year
Mo	t the c by the achec	hysi	9 Unknown		9 Unknown										
S. F	ss that gned b	by P	Part II. Other significa	nt conditions	contributing to death bu	at not result	ting in the	underlying cause gi	ven in Part	:1.	23e. Did to	obacco us	se contribut	te to the	cause of death?
Drd Drd	requires een sigr	ted	1			_		<u> </u>			1 🗆 Y	/es 2 □]No 3[] Proba	bly 4 Unknown
子なx も Vital Record	law r nas be	Completed									24a. Was autop	ISV	24b. Were	e autops	sy findings available pletion of cause of
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4 #	Physician; this certific	Be	25. Was case referred examiner?		Hospital:			Ot	la au.	ce of Death (Ci					
ō	Phys r this ral dii	: To	1 Yes 2 No 27. Manner of Death)	1 M Inpatie		R/Outpat 28b. Time	ient 3 🗆 DOA	4 LI N	Nursing Home	5 Resid			Specify)	
Division	Attending r death. sctor; After oy the fune	ition		5 ☐ Pending investigation	28a. Date of Injur (Month, Day	, Year)	Injur	y Wo	rk?]Yes 2[Describer	iow injury	occurred		
Visi	Atter	ifice		6 Could not be determined	28e. Place of Inju	ıry - At hom	ne, farm,	street, factory, office		28f.	Location (S	Street and	d Number o	r Rural	Route Number,
Ö	tal or rs afte al Dir	Certification:									City or Tou				
	To the Hospital or Attending Physician; The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:		(Check only 2	☑ Certifying Pf ☑ Medical Exar	nysician: To the best of miner: On the basis of	examination	ledge, de on and/or	eath occurred at the	time, date a	and place, and eath occurred a	due to the	cause(s) date and	and manne	er as sta	ited. he cause(s)
	To the within 2.	Medical	one) 29b. Signature and title		and manner sta	ited.			se number				e signed (M		
	6	-	290. Signature and title	an a d d l	272	è			S - 000						
	1.1		30. Name and address	s of person who	completed cause of de	eath (Item 1	23a) (Tun				1	FEBRI	UHKY	25	, 2009
	211		JAMES Y	MD.	# 4940	EAST	ERN	AVENUE	BAIT	IMORE	MD	2122	4		
	Sta		31. Date filed (Month		32. Registra	Signa	A. No		FF 10 1		,	-			
	Regist	ar	MARUU	, 6000	7	4/									

amend #5 PerInf G889 3/18/09 JH State of Maryland / Department of Health and Mental Hygiene 200 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 3:40 A.M 16, February Marlene R. Adelman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5450 Whitley Park Terrace, # 501 Montgomery Bethesda 8. Date of Birth (Month, Day, Ye Ian. 31, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Year. Months Hours 1935 Wash. D. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the "Acadeal Examinat intest by refilled at 1 X Yes 2 No Directo Maryland | Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 5450 Whitley Park Terrace # 501 20814 <u>U.S.A.</u> Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 2 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Rosenberg Daniel Diener ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20814 19a. Informant's Name/Relationship (Type. Print) 5450 Whitley Park Terrace, # 501, Bethesda, Md Edwin Adelman - Husband item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 2/18/2009 Olney, Maryland 4 □ Donation 5 □ Other (Specify) M00564 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service License Donald (1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 8 Months Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Lisease or i rjury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably X ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in b 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier end manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number February 16, 2009 D32407 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph M. Haggerty, M. D. 9707 Medical Center Drive, # 300, Rockville Md. 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 18 2009

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2000

06772

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Extrator, as the putified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1360 Stat

	1 - For State Registrar	Cei	rtificate of Deat	h	Reg. N	10 Z U U	2 00112
	Decedent's Name (First, Middle, Last)			2	2. Date of Death		3. Time of Death
n	Marilyn Joyce Allen			I	Month Eebruary	11, 2009	3:30 PM
al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	n of Death		4c. County of Dea	ath
	Anne Arundel Medical Center		Annapolis		A	nne Arur	ndel
	5. Social Security Number 6. Sex 7. Age (In yrs. le		If Under 1 Year If Und Months Days Hour	ler 24 Hrs. 8	B. Date of Birth (Month, Day, Yea	9. Bi	rthplace (State or Foreign country)
	472-32-7628 1□M2XF 74	Yrs.	34,0				innesota
	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	ncation				10d. Inside City Limits
ō			oddon.				XXYes 2 □ No
ect.	Maryland Prince George's Bow:	ie	10f. Zip Code		100.0	Citizen of What C	ountry?
₫			20715		USA		ountry:
Funeral Director	4913 Rocky Spring Lane 11. Marital Status 12. Was Decedent Ever in U.S	13	Was Decedent of Hispanic	Origin? (Speci		14. Race - Am	erican Indian
ᆵ	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	, 10.	If Yes, specify Cuban, Mexic	can, Puerto Ri	can, etc.)	Black, Whi	
	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 □Yes 2 X No <i>Spe</i> c	ify:		Specify: V	White
Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during m	net of working	16b.	Kind of Business	s/Industry
ᇍ	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)	iost or working			
င်	3	Regis	tered Nurse			rsing	
å	17. Father's Name (First, Middle, Last)				First, Middle, Maid	en Surname)	
으	Gilbert W. Ovist	I			Nadsky		
	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Nur				Zip Code)
	Mark S. Allen/ Son 20a. Method of Disposition 20b. Pl		tbrook Lane	Dat		Location - City or	r Town State
	The Burial 2 Al Cremation 3 herroval from State	metery, crer	osition (Name of matory or other place)				
	4 ☐ Donation 5 ☐ Other (Specify) A † 1 :	antic	Crematory Name and Address of Fac	$\frac{2}{13}$	2009 Gle	n Burnie	<u>MD</u>
	21. Signature of unpercentage	,	2. Name and Address of Fac	Robei	rt E. Eva	ns Funer	cal Home
\dashv	23a. Part 1. Enter the disease, or complications that caused the death		6000 Annapol			MD_207.13	Approximate
	shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
	disease or condition resulting in death) Cholangiocat Due to (or as a consequence)		la .				3 Years
		01100 0171					
ğ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					
Examiner	that initiated events C.						
	resulting in death) Last Due to (or as a consequence of the control of the contro	ence of):					
edical	d						
ΣΙ	IF FEMALE:						
an	23b. Was decedent pregnant in the past 12 months?	death 3[Ectopic pregnancy			23d. Date of de Month	elivery Day Year
Physician	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5L	Other (specify)				,
	Part II. Other significant conditions contributing to death but not result	Iting in the u	nderlying cause given in Pa	rt I.	23e. Did tobacc	o use contribute t	to the cause of death?
Completed by					1 ∐ Yes	2 X No 3 □ F	Probably 4 ☐ Unknown
ete E		•			24a. Was an	24h Woro a	urtoney findings available
티			-		autopsy performed?	? death?	utopsy findings available completion of cause of
3	25. Was case referred to medical		QC DIA	an of Death /	1 Yes 2X	No 1 □ Ye	s 2□No
o Re	examiner? 1 Yes 2 X No Hospital: 1 Inpatient 2 E	-B/Outpatier	044		Check only one) e 5 ☐ Residence	6 □Other /Sn	ocifu)
<u> </u>	27. Manner of Death 28a. Date of Injury	28b. Time of			d. Describe how in		bully)
at 10	2 Accident investigation	injury	M t ☐Yes 2	□No			
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office	28	f. Location (Street City or Town, Sta	and Number or F	Rural Route Number,
S		,					
Medical Certification: 10	29a. Certifier (Check only (Check only) 1♣ Certifying Physician: To the best of my know 2 ■ Medical Examiner: On the basis of examinat	vledge, deat ion and/or in	h occurred at the time, date	and place, ar	nd due to the cause d at the time, date a	e(s) and manner a and place, and du	as stated. le to the cause(s)
Med	and manner stated.						
-	29b. Signature and title of certifier		29c. License numbe	71	290. 1	Date signed (Mon	ui, Day, Idai)
	· vertical (earl)	00-) /T	D16364		2/1	1/2009	
	30. Name and address of person who completed cause of death (Item			Annas	olic MD	21/01	
3			oad Suite 300	Annapo	JIIS, PID	<u> </u>	
	FEB 1-7-2009	pa	Med				

Registra

Physicia /Medica Examine

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Marylan	Certif	ficate of D	eath		Reg. No.	0)	0011
Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
Wil	liam Andrefs	kv			Februa.	Day	Year	1:05 AN
4a. Facility Name (If not institution, give so	treet and number)	41:	b. City, Town, or L PERRY	ocation of Death		4c. County		
5. Social Security Number 6. Sex		last birthday) If	f Under 1 Year Ionths Days	f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day April 1	y, Year) 2,1918	9. Birthpla Countr Penn	ace (State or Foreigry) Sylvania
Usual Residence of Decedent								
I0a. State 10b. County	10c. City	y, Town or Locati	ion				10	d. Inside City Limits
Maryland Harford			Aberdeen					XXYes 2□No
0e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Countr	ry?
462 Manor Court			21001				.S.A.	
11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever in U.: Armed Forces? XXYes 2 ☐ No	If Ye	s Decedent of His es, specify Cuban	Mexican, Puert	pecify Yes or No- o Rican, etc.)	Blac	e - America k, White, et	c.
3√Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1939	-60	Yes XXNo	Specify:	-	Specify 16b. Kind of Bu	WII	ite
15. Decedent's Educ (Specify only highest grade	completed)	(Give kind	d of work done du NOT use retired)	ring most of wor	king	TOD. KING OF BU	Siliess/IIIuc	15ti y
Elementary/Secondary (0-12) Twelve Years	College (1-4or 5+)		er Serge	ant		United	State	s Army
17. Father's Name (First, Middle, Last)		,,,,,,,			ne (First, Middle,			
· · ·	Andrefsky				Mary Se			
19a. Informant's Name/Relationship (Typ	, ' \	1	Address (Street ar			· ·		_
Walter Andrefsky	(son)		nor Cour	t, Aber			2100	-
20a. Method of Disposition 1 □ Burial 2√□ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	amoval from State	* '	on (Name of ory or other place) & Co., I	4	Date 22/09	- ^{20c. Location} Vest Che Penns	ster,	
21. Signature of Funeral Service License	all mon s	Lee Lee	lame and Address A. Patt Perryvi	of Facility erson & lle. Ma	Son Fur		me, P	
shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or as a consequence of	uence of): Cer uence of): Cqner						Onset and Death
							1	
	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ldeath 3 ⊟ Eo	ctopic pregnancy ther <i>(specify)</i>			23d. Dat Mo	e of deliver	y Day Year
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ldeath 3 □ Eo death 5 □ O	ther (specify)	in Part I.		Mo obacco use contr	nth [Day Year
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ldeath 3 □ Eo death 5 □ O	ther (specify)	in Part I.	1 🗆 \	Mo obacco use contr ves 2 □ No	nth [ribute to the 3□ Proba	Pay Year e cause of death?
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ldeath 3 □ Eo death 5 □ O	ther (specify)	in Part I.	1 □ \	Mo obacco use contri /es 2 □ No an 24b. Valy ssy	ribute to the	Pay Year e cause of death? ably 4 [X] Unknow sy findings available pletion of cause of
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	ldeath 3 □ Eo death 5 □ O	erlying cause giver	26. Place of Dea	1 🗆 \\ 24a. Was autop perfo	Mo obacco use contri res 2 □ No an 24b. Vo rmed? 2 1월 No	ribute to the 3 Proba	Pay Year e cause of death? ably 4 X Unknow sy findings available upletion of cause of
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23b. Was decedent pregnant in the past 12 months? 1	1 Uve birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 □ Edeath 5 □ O	erlying cause giver 3 DOA Other 28c. Injury Work?	26. Place of Dea : 4	24a. Was autop perfo	Mo obacco use contri fes 2 No an 24b. V ssy rmed? 2 12 No	ribute to the 3 Proba Were autoporior to comdeath? In Yes 2 er (Specify,	e cause of death? ably 4 1 Unknow sy findings availably pletion of cause of
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Stat Registra

			For State of Mal State Registrar	ryland / Depa <i>Cer</i>	ertment of He <i>rtificate of De</i>			ene 2009	06774
ī	Physici		1. Decedent's Name (First, Middle, Last) James Lee	۸٠	vors Ir	2 <i>L</i>	Date of Death	Day Year	3. Time of Death
100	/Medic Examin		4a. Facility Name (If not institution, give street and number)	A	yers, Jr. 4b. City, Town, or Lo		Ebruary	4c. County of Death	
and the			PANNSAVA REGIONAL MEDERL	Come		16 Under 24 Hrs. 8		Hom	
ı,	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 M 2 □ F 7. Age	(In yrs. last birthday) 44 Yrs.		Hours Min.	Date of Birth (Month, Day, Y) 5-20-196		place (State or Foreign ntry) r land
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	a-f sh	ctor	MD Wicomico	Salisbu	ry				1 □Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code			g. Citizen of What Cou	ntry?
	eath w	Funeral	1516 Woodridge Drive 11 Marital Status 12. Was Decedent Ev	ver in U.S. 13 \	Vas Decedent of Hisp			USA 14. Race - Amer	can Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Evaluation of the Armed Forces? 1 □ Yes 2 ☒ No lif Yes, Give Year or Dates:	0	Vas Decedent of Hisp fYes, specify Cuban, I∐Yes 2∑∏ No	Mexican, Puerto Ric	can, etc.)	Black, White,	etc.
21215-0036	72 hou "natura dicel E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation	ion ring most of working	16	6b. Kind of Business/Ir	dustry
72	filed within Hygiene. other than "	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	•)	00 NOT use retired) food Manag	rer		Grocery St	ore
	2 should be filed w n and Mental Hygie is marked other t raumatic event, In	Be C	17. Father's Name (First, Middle, Last)			8. Mother's Name (F			
Maryland	should be and Mental s marked o umatic eve	10	James Lee	Ayers, S		Blanche		Adkins	
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		•			City or Town, State, Zi	,
ē,	is 1 and 2: of Health a item 27 is		David L. Brooks - Brother 20a. Method of Disposition		sition (Name of natory or other place)			.ry 1 and 218 0c. Location - City or T	
Baltimore,	Pages ment of I ant: If ite ury or o		1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Wicomico N	Memorial P	k. 2-18-2		alisbury,	Maryland
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		Name and Address 5 E. Main			ral Home ry, Maryla	nd 21804
1	Physician /Medical Examiner	er	Sequentially list conditions b. LUNG		er the mode of dying,			TASIS	Approximate Interval Between Onset and Death A N. GeNTH
68760,	ficate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):					
P.O. Box 68	sath certi attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of the pregnant at the pregnant	PEtal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliv	rery Day Year
	law requires that the das been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but SEIZURE DISCROER	not resulting in the ur	nderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Reco	The law rec te has bee age 2 shou	Completed	M t				24a. Was an autopsy performe 1 □ Yes 2€	prior to co	opsy findings available ompletion of cause of
/ita	ilcian: Th certificate ector, pag	BeC	25. Was case referred to medical			26. Place of Death (2140 12163	20110
_	Physic this crail dire			nt 2 ER/Outpatien		4 L Nursing Home	e 5 Residence d. Describe how	ce 6 Other (Spec	fy)
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident investigation	Year) Injury	Work? M 1 □ Ye	es 2 🗆 No		et and Number or Rui	al Route Number,
	e Hospita 24 hours 9 Funeral letely fillec	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or in					
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License r	number	290	d. Date signed (Month,	Day, Year)
			Guhes no		0509	29		2-13-09	
_	Be		30. Name and address of person who completed cause of dea	1405 5.1		ST. SALISI	BURY, M	10 21804	•
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar	r's Signature	barles				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11:40 PM 02 mar T 2009 bn Basi /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Medical Center trne Arundel runde thoupolis Date of Birth (Month, Day, Year) If Under Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**№** M 2□ F NONE 02 2009 Director 1.5 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Marical Exprehence to notified at 1 ☐ Yes 2 No Director arroll ton 6 conge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20 States United Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩No 2 Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None NONE 0 0 18. Mother's Name (First, Middle, Majden Surname) 17. Father's Name (First, Middle, Last) Be Numye Khalida Mohamed Kasi Aweys ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85th Ave of Health of Item 27 ls 20784 New Correllton, Md Omar mother Khalida other t 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 Removal from State 6 Department of Important: If any Injury or once. Z 4 ☐ Donation 5 ☐ Other (Specify) Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Xtreme **Physician** 44 minuta disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the irector, page 2 s autopsy performed? 1 □ Yes 2 🗆 No 2 StN After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Mapatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation nours after death.

neral Director: Af

filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Socretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State

Registrar

handra

raham 2001 Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00060205

PKWY Annapolis, Md 21401

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FEBRUARY ,2009 1429 TAILIL LA'KEITH AKBAR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CL INTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1**X**□ M 2□ F 28.1970WASH. Director 578-98-2878 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director DC<u>WASHINGTON</u> 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with UNITED STATES 20019 2921 NELSON PL SE #3 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2x No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL WORKER PRIVATE h and Mental Hygie 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MICHELLE D. SHINGLER JAMES SMITH 2 19a. Informant's Name/Relationship (Type. Print) MOTHER-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is any injury or other trau 2921 NELSON PL., SE #3 WASH., D.C. 20019 MICHELLE BUCKNER-SHINGLER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/09 BRENTWOOD, MD. 4 □ Donation 5 □ Other (Specify) FT. LINCOLN CEM. : 21. Signat re Funeral Service Licens 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., NE WASH., D.C. 20002 23a. Part 1. Enter the diseas , /r complications that caused the shock, or heart failure. List only one cause on each line. complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician: The 2 🖵 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes directôr, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 I Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🖸 Inpatient 1 ☐ Yes 2- ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1. Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0066719 MD 30. Name and audress of person who completed cause of death (Item 23a) (Type, Print) PATRICKS DR \$203 WALDERF 10 ST. 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar		State of Ma	aryland /	•	artment of F <i>tificate of</i>		Mental Hy	/gieni Reg. Na		00111
				e (First, Middle, Las	st)					2. Date of D	eath		3. Time of Death
	Physici /Medic		0r1ando	Aguiler	·a					Month Februa	rv 1	o 2009	6:00 а м
	Examin		4a. Facility Name (/	f not institution, give	street and number)			4b. City, Town, o	r Location of Death			c. County of Deat	1
	*		St. Thoma 5. Social Security N	s Moore N		d Rehab		Hyattsvi			P	rince Ge	
b	Funeral Director		579-13-8	255 ¹	ex 7. Ag	e (In yrs. last l 0	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	1'9'38	9. Birth Co.	nplace (State or Foreign untry)
	and		Usual Residence of 10a, State	10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
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	r 28a	irec	10e. Street and Nur		ic1y	DIIVE	:1 01	10f. Zip Code			10g. C	itizen of What Co	untry?
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	dea	ner	11. Maritat Status		12. Was Decedent Armed Forces?		13.		dispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N		14. Race - Ame Black, White	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 Ie marked other then "natural", or Iteme 23e or 28e-f ehow other traumatic event, the Madical Examinar must be rediffed at	by Funeral Director	1 ☐ Never Marri 3 ☐ Widowed	ied 2½∏ Married 4 ⊡Divorced	1 ☐ Yes 2 ☑ tf Yes, Give Year or Dates:	No			Specify: Sal			Specify: His	
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ano	d be i	To Be	Liberate										
ary.	shoul nd Me marl	F		ame/Relationship (Type, Print)	15	9b. Mailir	ng Address (Street	Maria de				ip Code)
	elth a		Mayra A	Aguilera/	daughter	9	802	Rosenste	11 Ave, S	Silver S	Spri	ng, MD 2	0910
ore.	of He fittern		20a. Method of Dis		Removal from State	20b. Place ceme	of Dispo tery, crer	sition (Name of natory or other pla	сө)	Date	20c. L	ocation - City or	
Ĕ	Page ment o ant: If ury or			5 Other (Specify		Gate	of H	eaven Ce	metery 2/	14/2009	S	ilver Sp uneral H	ring.MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: If item 27 le marked other then 'eny injury or other traumatic event, the Managone.		21. Signature of Fu	ineral Service Licer	ris kal	1	4	Name and Address 217 9th	ss of Facility Manager St. NW Wa	arsnall shingto	n Do		ome
			23a. Parti. Enter t	he disease, or com	plications that caused one cause on each ti	d the death. D	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause	(Final			tic	Cardiova	scular Di	Sease			Onset and Death
	/Medical Examiner		resulting in death)		a	a consequenc							years
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-	- FR 65		IF FEMALE:							-			
.O. Box	nt the death certif by the attending tached for use a	Physician/M	23b. Was deceden in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	very Day Year
Δ,	de de				ontributing to death b		j in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rdg	w requires been sign should be	edt	Coron	ary Arte	ry Disease	:				10	Yes 2	2□No 3□Pro	obably 4 Unknown
Division of Vital Records,	aw 2 st	Completed by	Congest	ive Heart	Failure					24a. Was		24b. Were au	topsy findings available completion of cause of
<u>=</u>	Tate page	Con								perf	ormed?	death?	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case reter examiner?	rred to medical	Heavitali			100	26. Place of Dea				
of	Phys this ral di	. To	1 ☐ Yes 2 ☑ 27. Manner of Deat			ent 2 ER/	Outpatier	I 3LI DOA		ome 5 Res		6 □Other (Spec	cify)
0	if er	tion	1 ⊠Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Da	y Year)	Injury	Wo	rk? Yes 2 □ No	280. Describe	now inju	ury occurred	
/isi	Atten r deal actor: by the	Ifica	3 🗌 Suicide	6 Could not be	28e. Place of th	jury - At home,	tarm, str	eet, factory, office					ral Route Number,
ō	s efte	Certification:	4 🗍 Homicide		building, et	tc. (Specify)				City or To	own, Stai	te)	
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 △ Certifying Ph 2 ☐ Medical Exam	ysician: To the best niner: On the basis o and manner st	of examination	lge, deatl and/or in	n occurred at the tive stigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause(, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the Comp	ž	29b. Signature and	title of certifier				29c. Licens			29d. D	ate signed (Monti	n, Day, Year)
			1 doe	de	Lenos	٩		D01	852		Feb	ruary 10	,2009
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			Paul A. 31. Date filed (Mon	Devore MI	4203 Que	ensbury	Roa	ıd Hyatts	ville MD	20781			
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Joseph R. Brungardt 10:39p M February 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montcomery 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F 60 Director 562-76-6441 May 27, 1948 CA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Modral Evan in a number of the mode. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 121 Bluff Terrace 20902 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2 If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No 2 Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Letter Carrier 2 Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Brungardt ျှ Sheila Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Marianne Templeton /Wife 121 Bluff Terrace, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction 1 day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 1 □Yes 2 X No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🕱 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Director: in 24 hours the Funeral Directory of filled in within 2 To the I

2

29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOOR VUDI D19192

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARRY

3941 PERLARA DRIVE WHEATON, 90 20906

State Registrar

Medical

WELL IND 31. Date filed (Month, Day, Year) . Registrar's Signature FEB 18 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 2:45 pm Florina Rosa Brienza February 2009 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Silver Spring Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F Months Days Hours Min. Director 577-20-3649 88 October 15, 1920 District of Columbia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho the Modical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? · death v Funeral 10521 Edgemont Drive 20783 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. þ Specify 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumatio. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Biagio Vagnoni Rosa Capone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Brienza - Daughter 3824 Water Drop Court, Burtonsville, Maryland 20866 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 02/18/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate se (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 5 months /Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, along the manager cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran <u>Dementia</u> Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical Failure to Thrive IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No P.O. ed by the detached 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ၉ 1∐ Yes 2.2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death

Director: A

d in by the f 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours aft i**e Funeral Di** oletely filled ir Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MESOM D0059649 February 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechukwu Damian Mbonu, M.D., 9501 Old Annapolis Road, #302, Ellicott City, Maryland 21042 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar FEB 18

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0 0 9

		-	State Registrar			ertificate of	Death	i	Reg. No.	, 0 5	00,00
	Physicia		1. Decedent's Name (First, Middle, Mary Elizabeth Box					2. Date of Dea Month February	Day	Year	3. Time of Death 8:56p M
	/Medic Examin		4a. Facility Name (If not institution, 10501 Tenbrook Dr.			4b. City, Town, o Silver Sp	r Location of Death ring		Montgo	ty of Death Omery	
	Funeral Director		043-68-5289	5. Sex 1 □ M 2 🖾 F	(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Oct. 16,	h y, <i>Year)</i> 1 962	9. Birthpl Count	ace (State or Foreign ry)
	show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10	0d. Inside City Limits
1	rouifier	Funeral Director	MD Montgom	ery	Silver Sp	oring 10f. Zip Code			10g. Citizen of	What Count	
	23a or	ral D	10501 Tenbrook Dri			20901	li and Oddina (O		USA	Amaria	an Indian
)36	should be filed within 72 hours after beaut with the waryland and Mental Hygiene. and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinational De notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 A Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Evarmed Forces? 1		13. Was Decedent of H If Yes, specify Cub 1 □Yes 2X□ No	an, Mexican, Puert Specify:	o Rican, etc.)	Speci	ace - America ack, White, e ify: W	
20-0-1	"natura	leted	15. Decedent's (Specify only highest	Education grade completed)	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation during most of wor	king	16b. Kind of I	Business/Ind	ustry
212	a within giene. er than in the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	.)	countant				Governm	ent
_	< _ m @	To Be (17. Father's Name (First, Middle, L Joseph Fitzgerald				18. Mother's Nan Bertha	ne (First, Middle, a Harju	Maiden Surna	me)	
Mar	Pages 1 and 2 should be trainent of Health and Mentiant: If item 27 is marked lury or other traumatic e		19a. Informant's Name/Relationshi John E. Bodkin /	p <i>(Type. Print)</i> Husband	19b. M	Mailing Address <i>(Street</i> 01 Tenbroo k I	and Number or Au Drive, Silve	ural Route Numb er Spring,	er, City or Town MD 2090	n, State, Zip I	Code)
ore,	ges 1 ar t of Hea lf item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation	B ☐ Removal from State	1	isposition (Name of crematory or other pla		Date	20c. Location	•	
altim	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service U		Metropol	itan Cremator 22. Name <i>a</i> nd Addre Francis J. (ase of Facility	.6, 2009 eral Home		kria, VA	-
Ö	a in the d		23a. Part 1. Enter the disease, or o	aucwar	the death Do no	500 Universi	ity Blvd. W	est, Silve	er Spring	, MD 20	Approximate
· F	hysician		shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each line	Leiomyosa		ing, each ac dardia	o o, 100p			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)	:					
0	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events	b. Due to (or as a	consequence of)	:					
00, 0	icate be executed physician and the burial-transit	al Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of)	;		*****			
k 68760,	ng phys	Medical	IF FEMALE:	d							·
P.O. Box	ne death certific the attending p thed for use as i	Physician/	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 😿 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 Pregnant at 9 Unknown	2 🔲 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			Date of delive Month	ery Day Year
ds, P.	ures that the de signed by the a d be detached f	2	Part II. Other significant condition	ns contributing to death bu	t not resulting in t	he underlying cause gi	ven in Part I.				ne cause of death?
Division of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed						24a. Was auto perfo 1 □ Yes	psy ormed?	o. Were autoperior to condeath?	psy findings available inpletion of cause of
Vita	Physician: The rthis certificate h ral director, page	BeC	25. Was case referred to medical examiner?	Hospital:		Ot	hor:	ath (Check only	one)		
n of	Phy: rahdis rahdi	Certification: To	1 ☐ Yes 2 💆 No 27. Manner of Death 1 💆 Natural 5 ☐ Pending	28a. Date of Injur	nt 2 ☐ ER/Outp ry 28b. Tir (, Year) Inji	me of 28c, Injury	ury at ork?	Home MX Resi 28d. Describe	how injury occi		y)
isio	deat deat ctor: y the	fication	2 Accident investig 3 Suicide 6 Could n	ot be 28e. Place of Inju	iry - At home, farm	M 1 E]Yes 2 □No	28f. Location (Street and Nur	nber or Rura	l Route Number,
<u>S</u>	nital or / urs after ral Dire		4 Hornicide	bullating, etc		death accounted at the	time, data and place		wn, State)	mannar as s	totad
	To the Hospital or A within 24 hours after To the Funeral Direst completely filled in by	Medical	29a, Certifier 1 X Certifyin (Check only 2 Medical in one)	g Physician: To the best of Examiner: On the basis of and manner sta	examination and	or investigation, in my	opinion, death occ	urred at the time	, date and plac	e, and due to	the cause(s)
	Talk to mo	Σ	29b. Signature and title of certifier	M	an?		se number 3177		29d. Date sign		
	12		30. Name and address of person John Wallmark	who completed cause of de 1707 Medical Cer	eath (Item 23a) (T	ype, Print) Suite 300, F	Rockville M	D, 20850			
	Sta Regist	ate trar	31. Date filed (Month, Day, Year) FEB 18	-	ar's Signature	backs					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 21, 2009 **Physician** 9:50 AM Cecil Calvert BITTINGER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington 322 West Wilson Boulevard Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Funeral Days Hours 217-32-7070 1 1 M 2 □ F 73 Director Sept. 10,1935 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 'natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1K Yes 2 No Maryland Washington Hagerstown Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 322 West Wilson Boulevard Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XX/es 2 No 195 If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene "instural", or iter important: if item 27 is marked other than "natural", or iter any highly or other traumatic event, the Medical Examilies and any in 1 Never Married 2 Married 1958-Baltimore, Maryland 21215-0036 white 1 □Yes 2X No Specify 9 Specify 1964 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland state police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy E. Downin Cecil Bittinger ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 West Wilson Boulevard, Hagerstown, Maryland 21740 Donna G. Bittinger - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 25,2009 Hagerstown, Minnich Funeral Home Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 200 ၉ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Matural 1 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ר 24 hours aff ie Funeral Di oletely filled ir

WH-12+

within 2

State Registrar

29b. Signature and title of certifier

29a. Certifier

Medical

M 32. Pegistrar's Signature

d address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

nword

09-01074 Carl Bailey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- F	State of Maryland / De	Certificate of	Death			Reg. N	lo	009 06	
Physician/		nistrar Decedent's Name (First, Middle,Last)				2. Date Month	Day	y Year	3. Time of Death 1605 hrs	
al Examine	r	Carl T. Bailey		1b. City, Town, or	Location of D		uary 5, Ž	4c. County of		
	48	. Facility Name (if not institution, give street and number) 302 Mangrove Road		Severna Pa				Anne Aru		
Funeral Director			yls. last birtinary			_	e of Birth (M	9. Birthplace (State or Foreign Country) Hawaii		
	U	Usual Residence of Decedent								
nd how any ce.		id. State	Severna P					1 Yes 2 1		
ith the Maryland \$ 23a or 28a-f show a profiled at once.		ne. Street and Number 302 Mangrove Road		10f. Zip Code 21146				USA		
and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland feath and Maryland and 2 should be a s	uneral	I. Marital Status X Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 Yes 2 X	If Yes, specify Cuban, Mexican, Puerto Rica			? (Specify Ye ruerto Rican, e	s or No- etc.)	- American Indian, Black, e, etc. White .		
urs after	g L	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete.	ad\ 16a Decede	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
in 72 ho	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 4 Unemployed					yed			
permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica		7. Father's Name (First, Middle, Last)	Months.				First, Middle, Maiden Surname) Graham			
Mental Marked marked event,	To Be	Clifford Herbert Bailey 9a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stre	et and Numb	er or Rural Ro	al Route Number, City or Town, State, Zip Code)			
th and th 27 is tumatic		Elizabeth Feke/ Cousin	1121 20b. Place of Dispo		g Broc	k Lane	Che	sterla Oc. Location	nd, OH 44026 - City or Town, State	
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ermit. P eepartme inportar	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22 B 40	Name and Address	S of Facility S SONS	P.A.	Seve	rna Pai	rk Funeral Hork, MD 21146	
hysician	-4	23a. Part I. Enter the disease, or complications that caused the	death. Do not enter	the mode of dying	g, such as car	rdiac or respir	atory arrest	t, shock, or he	eart Approximate Into Between Onset	
'Medical aminer	1	Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease								
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
	iner	if any, leading to immediate Due to (or as a consequence of):								
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bu, nte be executed hysician and e burial - transit	dical	UNPENDED AMENDED						Tax 5 :	T. dell's and	
Division of Vital Records, P.O. Box 90100, with Institute the death certificate be executed within 24 hours after death. To the Functral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi	- e	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	2	Fetal death Other (Specify)	3 Ectopic	pregnancy		23d. Date of Month	Day Yeal	
that the deaned by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknow			
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DIVISION Of VITAL RECORDS, F.O. Its also retained that the range death. The law requires that the she death. All Directors. After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Completed by					[']	autops perform	y ned?	prior to completion of caus death? 1 Yes 2	
tal KeC tian: The l certificate l ector, page		25. Was case referred to medical		26.Pla		(Check only o				
Vital hysician: this certifi I director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient			Other ₄	Nursing Hor		Residence 6 ow injury occ	Other: Scene	
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DIVISION OF pital or Attending Ph ours after death. cral Director: After t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)		28f. Location (Street and Number or Rural Route Num or Town, State)						
To the Hospital within 24 hours. To the Funeral completely filled		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my (Check only one) Wedical Examiner: On the basis of examiner:	knowledge, death or ination and/or invest	ccurred at the time	e, date and planton, death of	ace, and due	to the cause time, date a	e(s) and man and place, an	ner as stated. d due to the cause(s)	
To d withi To tt	Medical	29b. Signature and title of certifier 29c. License number O.C.M.E.					29d. Date signed (Month, Day, Year) February 6, 2009			
CAN.		30. Name and address of person who completed cause of de	eath (Item 23a)				4004			
12		Donna M. Vincenti, MD Assistant Medica	al Examiner	111 Penn Stre	eet, Baltim	ore, MD 2	1201			
	tate	31. Date filed (Month Day, Year) 2009 32. Registrar	s Signature.	and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 02 13^{Day} 2009 830 а м Arthur Brown 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Silver Spring Holy Cross hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, Days 1**™** M 2□ F Virginia 81 226-36-4704 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No Washington, DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20011 USA 128 Ouakenbos Street NW 12. Was Decedent Ever in U.S.

Armed Forces?

1X Yes 2 No11-16-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: Black 1 ☐ Yes 2X No res, Give Year or Dates: 2-13-1947 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Chauffeur 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Virginia Robinson Samuel D. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 908 South Belgrade RD Silver Spring, MD 20902 Rayfield Robinson/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Culpeper National cem 2-24-2009 Culpeper, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshalls Funeral Home 21. Signature of Funeral Service Licenses 4217 9th Street NW Washington, DC 20011 mar Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cancer of unknown primary 3d. Date of delivery Month Day Year se contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No

02-11312009

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be nettlied at any injury or other traumatic event, the Medical Examinat must be nettlied at any injury or other traumatic area.

Baltimore, Maryland 21215-0036

/Medical

Director

by Funeral

Completed

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attending physician and for use as the burial-tran signed by the a d be detached for director, After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🌣

this

To the Hospital

	resulting in death)	Due to (or as a consequence of): Liver metastases					
Exam	Sequentially list conditions, and any, roading to minimum action cause. Enter Underlying	Due to (or as a consequence of):			9		
	Cause (Disease or injury that initiated events	Obstructive Jaundio	ce				
	resulting in death) Last	Due to (or as a consequence of):					
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ctopic pregnancy ther (specify)		23d. Date of delivery Month Day Year		
d by Ph	_	ntributing to death but not resulting in the under Type 2 Diabetes Mel.		23e. Did tobacco	use contribute to the cause of deatl		
complete	\			24a. Was an autopsy performed? 1 □ Yes 2 ØNo	24b. Were autopsy findings avair prior to completion of caus death? 1 □ Yes 2 □ No		
Be	25. Was case referred to medical		26. Place of Dea	th (Check only one)			
	examiner? 1 □ Yes 2 🔼 No	Hospital: 1∭Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	6 ☐ Other (Specify)		
ation: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injur			
Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	28f. Location (Street ar City or Town, State	Location (Street and Number or Rural Route Number City or Town, State)			
Medical C	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of my knowledge, death or iner: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place tigation, in my opinion, death occu	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)		
ĕ	29h Signature and title of certifier		29c. License number	ate signed (Month, Day, Year)			

State Registrar

Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Barbara Supanich RSM,MD 1500 Forest Glen RD Silver Spring,MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death กลง Year Month Physician 9:20 pM 12 2009 Stanley Block February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Manor Care Potomac If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 🖾 M 2 🗆 F Yrs. Director 82 February 14, 1926 Maryland 215-22-2315 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in the other Exymine must or notified. 1 ☐ Yes 2 ₹ No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1001 South Belgrade Road 20902 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 No Specify. ð 3 ☑ Widowed 4 ☐ Divorced White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Psychologist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Paul Block Anna Shreiberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Schmidt - Daughter 1001 South Belgrade Road, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State d ☐ Other (Specify) 4 ☐ Donation 02/15/2009 Lebanon Cemetery Adelphi, Maryland ral Service Licer 22. Name and Address of Facility 21. Signature of Fu Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate 23a. Part 1. Enter the disease, shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, pnly one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Respiratory Distress Due to (or as a consequence of): Physician/Medical Dementia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 🗆 No 1 Tyes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 🗵 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20274 February 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Kirti Vohra, M.D.,

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

7710 Bradley Blvd., Bethesda, Maryland 20817

32. Registrar's Signature

			For State	State of Mar	yland / [Department of F Certificate of			jiene _{eg. No.} 2 () (7 9	06	785
			Registrar 1. Decedent's Name (First, Middle, Las	Certificate of	2. Date Mont				3. Time o			
	Physicia /Medic		Ruth Lucille Karnes						4.0	Year 009	12:25	5 P ^M
Ā	Examin	100	Ruth Lucille Barnes February 12, 2009 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
			Shady Grove Adver 5. Social Security Number 6. Se	entist Hospital Rockville Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dat					Montgomery of Birth h, Day, Year) 9. Birthplace (State or F Country)			or Foreign
	Funeral Director		579-20-4743	☐M 2 X F		Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day 10/10/1	920		yland	
	yland now at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				1	0d. Inside C	
	e Mar Sa-f sh tified	ctor	Maryland Montgome	ry	Gaith	ersburg						2 ∑ No
	vith th	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W		-	
1	ns 23	Funeral	333 Russell Avenu	12. Was Decedent Ev		13. Was Decedent of H	377 Hispanic Origin? (Sp	ecify Yes or No-	United 14. Race	- Americ	an Indian,	
336	be filed within 72 hours after death with the Maryland that lygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub		Rican, etc.)	Specify:	, White, Wh	etc. ite	
5-0036	72 hou natura dical E	eted	15. Decedent's Ed	ucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of work	ing I	16b. Kind of Bus	iness/In	dustry	
2121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	life. DO NOT use retire	d) -		County	Gov	ernmer	1+
d 2	illed Hygid other ent, th	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>		01011	18. Mother's Name	e (First, Middle,			C L IXIII C I	<u> </u>
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, tl	To B	W. Wilson Briggs					May Mon				
Mar	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (7) Gretchen Rezash (. Mailing Address (Street			, . ,	,,	/	21701
d)	ges 1 and 2 should it of Health and Mer If Item 27 Is marke or other traumatic		20a. Method of Disposition	reisonal n	20b. Place of	2500 Waters: f Disposition (Name of ry, crematory or other pla		Date	20c. Location - C			21/01
altimore,	Pages nent of ant: If I		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State ')		Oak Cemete:	100	; ¹⁶ ,	Gaithers	sbur	g, MD.	
Balt	permit. Pages 1 Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licen	Zev)		22. Name and Address 10 East De					MD. 2	20877
S			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
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	/Medical Examiner		1	Due to (or as a	consequence	of):						
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)	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease of injuly that initiated events resulting in death) Last	c Due to (or as a	consequence	of):				- 1		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical E		.d	oonooquonoo	01).						
9	rtificat ng phy as the		IF FEMALE:									
P.O. Box	death certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1□Live birth 2 4□Pregnant at ti	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	у		23d. Date Mon		,	Year
o.	the de	hysic	1 □ Yes 2 □ No 9 □ Unknown	9☐Unknown	ine or death	5 □ Other (specify/ _						
	ires that the de signed by the a be detached t	by P	Part II. Other significant conditions of		not resulting in	n the underlying cause gi	ven in Part I.		bacco use contri			
o D	w require been signature		<u>Atrial Fibrillat</u>	ion					es 2□No :			
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a	'slclan: The law s certificate has b lirector, page 2 s	a)	25. Was case referred to medical				26. Place of Deat	1 Yes th (Check only or		∐ Yes	2 No	
<u>-</u>	hyslcl his cer I direc	To B	examiner? 1 ☐ Yes 2 ☐ No		t 2□ER/Ou	utpatient 3 DOA Oti	ner: 4 🗆 Nursing Ho	ome 5 ☐ Resid	ence 6 Othe	r (Specit	y)	
o uc	ding Ph	ion:	27. Manner of Death 1 ဩNatural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of 28c. Inju Injury Wo	ryat rk?]Yes 2 ∐No	28d. Describe h	ow injury occurre	ed		
Division or	ten leatl tor: the	ficat	3 Suicide 6 Could not be					28f. Location (Street and Number or Rural Route Num			nber,	
2	tal or safter al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify) City or Town, State)									
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical (examination ar	e, death occurred at the t nd/or investigation, in my						s)
	To the within to the comp	Me	29b. Signature and title of certifier			29c. Licen	se number	2	29d. Date signed			
	5		Machani		NV)	625	562		Februar	y 13	3, 200	19
			30. Name and address of person who or. Madhavi Hubbl	у М.Д. 990	1 Medi		Orive Rock	cville,	MD. 2085	0		
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 7 200	32. Registrar		bares						

DHMH 17 Rev 1/2001

09-01203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Timothy S Bryant State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 10, 2009 0437 hrs Timothy S. Bryant Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death La Plata Charles 6325 Fennell Place 9. Birthplace (State or If Under 1 Year | If Under 24Hrs: 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Oregan Hours Days N/A Director $_{1}XX_{M}$ 30 Jan 5, 1979 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State s 23a or 28a-f show a notified at once. 1 Yes 2 XXNo MD Charles LaP1ata Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 6325 Fennell Place United States 20646 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Married Yes Pages 1 and 2 should be filed within 72 hours after of nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", on or other traumatic event, the Medical Examiner m Yes, Give Yea Yes 2 XX specify: Widowed Divorced White ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Bartender Bar 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard Bryant Sharon Pirrone æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shannon Pirrone (sister) 5817 Gwinndale Place, Clinton, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 XX remation 3 Removal from State iportant: jury or oth Feb 16 2009 Lee Crematory Clinton, MD Donation 5 Other Specify 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licke ee Alexandria Ferry Road, Clinton, MD 20735 23a. Part I. Enter the disease, or complications that cauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Guns not Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (of as a consequence of). events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical æ examiner? Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ٩ 1 🗸 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury Certification Subject shot UNKNOWN Natural Yes 2 V No Pending To the Funeral Director: Feb 10, 2009 Accident Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 6325 Fennel Place, La Plata, MD determined (Specify) residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my cpinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month) State Registrar

Registrar's Signature Greecen

Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

1/8 2009

Patricia Aronica-Pollak MD.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:55 2009 EDWARD LEE BRIMER Feb. 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pocomoke City Worcester Hartley Hall Nursing Home 8. Date of Birth (Month, Day, Year) 5/4/1927 Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Maryland 81 Director 213-22-5903 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10a. State 1 X Yes 2 □ No Director MD Worcester Pocomoke City 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ms 23a or 7 21851 USA 917 Second Street death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 1 amy Injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ Post If Yes, Give Year or Dates: WWII 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Ellis Melvin Brimer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1936 Clarke Ave., Pocomoke City, MD 21851 Maurice Brimer (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Salem Methodist Cemetery 2/21/2009 Pocomoke City, MD 21. Signature of Funderal Service Licensee 22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4- mThy **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contified eb.16.2009 30, Name and address of person who completed gause of death (Item 23a) (Type, Print) SARAD R. BARAL; 1604 Mwket St XH5+1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Maryland		ertment of l ctificate of	Health and M <i>Death</i>		giene Reg. No. 20	09	06788	
			1. Decedent's Name (First, Middle, Last)					2. Date of Death 3. T			3. Time of Death		
	Physicia /Medic		Irvin Clarence Bramble						Month のみ	12	09	2337M	
	Examin		4a. Facility Name (If not institution	/			21	or Location of Death		4c. County		· ·	
Sec.			TENINSULA REGI 5. Social Security Number	6. Sex	7. Age (In yrs. las	t hirthday)	If Under 1 Year	I I/SbUPY	8. Date of Bir		COMIC 9. Birthpla	ce (State or Foreign	
	Funeral Director		213-24-4861	1 ½ M 2□ F	77	Yrs.	Months Days		July 3	th Year) 0, 1931	Ma r	yland	
			Usual Residence of Decedent										
	show	_	10a. State 10b. County Wic	comico	10c. City,	Town or Loc	cation Hebr	on			100	Inside City Limits X□Yes 2□No	
5	he Ma	Director	10e. Street and Number	- CALLICO			10f. Zip Code			10g. Citizen of W	hat Country		
3	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show unatic event, it e Medical Exeminal must be notified at	ä	102 Chapel Bra	nch Drive	<u> </u>		701. 2.ip 00d0	21830		US			
)	ms 2;	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.S.	13. V	Nas Decedent of	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No	14. Race	- Americar		
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212	d with giene er tha	Completed	Elementary/Secondary (0-12)	College (1-401 5+)		meatcutt	er		groce	ry st	ore	
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ā Z	2 se la la la la la la la la la la la la la		19a. Informant's Name/Relations Tracie B. Burt		ghter			op Road,			643	ode)	
စ်	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition				sition (Name of natory or other pla		Date	20c. Location -	City or Tow	n, State	
Ë	Pages nent of int: If its iry or o		12 Buriat 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		Market C	•	8/09	East Ne	w Mar	ket, MD	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce.		21. Signature of Funeral Service	Licensee			2. Name and Addr	Tn		neral Ho		A.	
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ف	rtificat ng phy as the	/ledi	IE EENAN E.		151				Y				
Box	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live	tcome of pregnand birth 2 Tetal of	death 3	☐ Ectopic pregnar			23d. Date Mor	e of delivery	ay Year	
0	he dea the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ∐ Preç 9 ∐ Unk	nant at time of dea	ath 5 L	Other (specify)						
σ.	w requires that the di been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of			cause of death?	
Records,	quires en sign uld be	ed by	Kumony	Embol	`				1 🗆	Yes 2 No	3 ☐ Probal	oly 4 🗌 Unknown	
ပ္တ	law rea as bee 2 sho	plet	Itm 0						24a. Was	an 24b. V	Vere autops	y findings available bletion of cause of	
	The late has page	Completed	Purkluson	5 Dise	2-51				perfo	ormed?	leath?		
Vita	ician: The certificate h rector, page	Be (25. Was case referred to medica examiner?	Hospital:			100	26. Place of Dea	th (Check only	one)			
ot	Phys r this ral dir	<u>구</u>	1 Yes 2 No 27, Manne Death	28a. Date	of Injury 2	R/Outpatier 28b. Time of	IL 3 LI DOA	4 Li Nursing n		how injury occurre	nce 6 Other (Specify)		
on	th. : Afte	ition	27. Manne: Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28d. Describe how injury oc Injury M 1 Describe how injury oc Injury M 1 Describe how injury oc Injury M 1 Describe how injury oc Injury							,,			
Division of	Atter	Certification: To	2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town							(Street and Number	treet and Number or Rural Route Number,		
	ital or irs afte ral Dir lled in												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, it is a completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying (Check only one)	Examiner: On the	e best of my know basis of examination nner stated.	rledge, deat on and/or in	h occurred at the evestigation, in my	time, date and place opinion, death occu	rred at the time	e cause(s) and ma , date and place, a	inner as sta and due to t	ted. he cause(s)	
	To th To th comp	Me	29b. Signature and title of certifie	1			29c. Licer	nse number		29d. Date signed	(Month, Da	ay, Year)	
		1	Whin				His	1627		2/13	109		
			30. Name and addless of person	who completed cau	se of death (Item			MENRALE	PK SI	THE 103	SAL	5 Birymi)	
	Sta		31. Date filed (Morting Pay, 103)	2009	Registrar's Signat				<u> </u>	•	2	1004	
	Registi	ar			-	THE STATE OF THE S							

			For State Registrar	State of Mary		artment of F <i>rtificate of I</i>		Mental Hyg ا	giene Reg. No 20	09	06789
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
,	/Medic		Frankie C. Baird	44		4h Cihi Taura ai	Location of Deat	02	4c. County	09	0313 M
	Examin	er	4a. Facility Name (If not institution, give st PENINSUUM REGIONA		Cente		Location of Deatl	1	'	comi	100
	Funeral Director		5. Social Security Number 6. Sex		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Apr 8,	h y, Year)	9. Birthp	place (State or Foreign
	D		Usual Residence of Decedent								0d. Inside City Limits
	arylar show	'n	10a. State 10b. County Wicomic		oc. City, Town or Lo Salisb						1X Yes 2 □ No
	the M 28a-f	Director	10e. Street and Number		Daile	10f. Zip Code			10g. Citizen of V	What Cour	ntry?
	3a or	al Di	28680 Ocean Gatewa	ıy		21801			US	A	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, it is included Evertring in unit by notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ₩ No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)		ce - Americ ck, White,	_
21215-0036	72 hours "natural" dical Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade)	Year or Dates: ation completed)	I (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	16b. Kind of Bi	usiness/In	dustry
12	within iene. than	dwo	Elementary/Secondary (0-12) 11th	College (1-4or 5+)	ille.		" etary		Ice	Crea	am
þ	e filed al Hyg other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,			
ylaı	should by and Mentite s marked	To	Frank James				Dora Mi				
Maryland	12sh thand 7 is m traum		19a. Informant's Name/Relationship (Typ Carroll McCloud/so		1	ng Address <i>(Street</i> 0 Ocean G					Code)
ē,	s 1 and 2 soft Health a item 27 is cother train		20a. Method of Disposition			osition (Name of matory or other place		Date	20c. Location -		own, State
E O	Pages nent of l ant: If its ury or o		1 ☐ Burial 2 【Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		y Cremato		/2009	Salisb	ury,	MD
Baltimore,	permit. Departr Importa any Inju		21. Signature of Euroral Service Licensee	Those		2. Name and Addre Lewis N. 1618 West				01	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused the	e death. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	0.1	Approximate Interval Between
~ 4.	Physician		Immediate Cause (Final disease or condition	Gran	Negati	we Sep	pis				Onset and Death
age of	/Medical Examiner		resulting in death)	Due to (or as a c	onsequ in e of):	1	,				
		Je.	Sequentially list conditions, it ally, south you have been accessed by the sequence of the seq	Die to (uras a o	unseque reacti)						
	ecuted nd transit	Examiner	that initiated events C.								
8760,	ficate be executed physician and s the burlal-transit	a Ex	resulting in death) Last	Due to (or as a co	onsequence of):						
	ficate g phys	edical	d.								
O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of a compart of the compart of the compart at the compart at the compart of	Fetal death 3	☐ Ectopic pregnand	у			ite of deliv	ery Day Year
σ.	that t ned by detac		Part II. Other significant cenditions cont	tributing to death but r	ot resulting in the ι	underlying cause giv	en in Part I.	23e. Did t	obacco use con	tribute to t	he cause of death?
rds	equires en sig ould be	ed by	Acute Rend	Farlu	ph.			1 🗆 `	Yes 22 No	3 ☐ Prol	bably 4 🗆 Unknown
Division of Vital Records,	The law re ate has be bage 2 sho	Completed							osy rmed?	Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 \(\sum No \)
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of	Physic ruthis care directly	-: To	1 ☐ Yes 2 ☐ No	1 Inpatient 28a. Date of Injury	2 ER/Outpatie	of 28c. Inju	rv at	dome 5 ☐ Resi	dence 6 Oth		fy)
ion	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	(ear) Injury	Wor	ḱ? Yes 2 □No				
Divis	il or Atte after des I Directol d in by th	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, st 'Specify)	reet, factory, office		28f. Location (: City or To		ber or Run	al Route Number,
	e Hospita 124 hours e Funera letely fille	Medical C		sician: To the best of r ner: On the basis of ex and manner stated	kamination and/or i						
	To th within To the	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe	ed (Month,	Day, Year)
	cal		Merch			D63	177		02/14/	09.	
	De,		30. Name and address of person who cor				C_{1}	bury n	n D =	100	,
	-	ate	31. Date filed (Month, Day, Year)	32. Registrar's		Shore Dr	, DATIS	pany 11	10. d	180	/

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 19:57 M 02 Mabe1 Virginia Battistone 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital
Social Security Number 6. Sex 7. Age (In yrs. Rockville Montgomery Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F Months 578-05-5557 91 Director 11/04/1917 VA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or Items 23a or 28a-f shovevent, the Medical Example; must be notified at Director 1XYes 2□No MD Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 20816 USA 5511 Cromwell Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ₺ No Specify: White Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. other than "r Federal Government College (1-4or 5+) Elementary/Secondary (0-12) Senior Program Analyst NIH 12 should be filed with and Mental Hygier
7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Galen Myers Una Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. <u> Catherine Battistone - Daughter 5511 Cromwell Drive Bethesda, MD 20816</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery | 02/21/2009 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 3401 Bladensburg Road Brentwood, MD 23a. Part 1. Enter the disease, obcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multi-Organ Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any leading transport cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Pneumonia and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>≽</u> icate has been siç ; page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 2 🗆 No 1 □ Yes 1 ☐ Yes Hospital or Attending Physician:24 hours after death.Funeral Director; After this certifica director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08006 416 17.09 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sujatha Ramaseshan

9901 Medical Center Drive Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 14 2009 0645 A Edith M. Boags Feb /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince Georges 9. Birthplace (State or Foreign Country)
So • Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09-02-1910 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ F 98 248-07-9899 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Evaminer must be notified at 1 Tryes 2 □ No Director MD Prince Georges Clinton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20735 7907 Elmwood Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 □Yes 2 ▼No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, It e Madical College (1-4or 5+) Elementary/Secondary (0-12) Clerk Typist Private Industry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I is marked of Emily Holmes Samuel Lee ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Elmwood Lane 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau Clinton, Maryland <u> Jonathan Boags (Son)</u> 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Summerville, 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 02-28-2009 4 ☐ Donation 5 ☐ Other (Specify) Pineland Cem So. Carolina ²² Name and Address of Facility Ralph Williams Funeral Service 1813 Potomac Ave.,SE; Wash.,DC Funeral Service Licensee/ 20003 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTERIO SCUME **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner pur Due to (or as a consequence of): physician Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 2 No 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Aatural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Baltimore, Maryland 21215-0036

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requires that the death certificate be executed

Box 68760,

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Records,

Division of Vital

or Attending

Hospital

State Registrar

Medical

ed (Month, Day, FEB 19 2009

17017KG

29b. Signature and title of certifier

(Check only

Name and addre

1/1

and manner stated

of person who completed cause of death (Item 23a) (Type, Print

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ER WALDONF, UD. TEGEZ

09-01106 Dominick Binstor		Please Type or Print in Black Indelible State of Maryland / Department	t of Health and			jible.	000 0670
Direction in	_	1- For State Certificate Registrar 1. Decedent's Name (First, Middle,Last)	of Death	12	Re Date of Death	g. No. 2	3. Time of Death
Physicia Medical Examir					Month ebruary 6		
A STATE OF THE STA		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	obligary o	4c. County	of Death
		1200 Westfield Road	Oxen Hill				George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Yea Months Day	n Hours Min			 9. Birthplace (State or Foreign Country)
Director		212-02-3242 1x M 2 F 26	Yrs.	Tiodio IVIIII	May 18	,1982	Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation				10d. Inside City Limits
<u> </u>		Maryland Prince George Clinton					1XX Yes 2 No
arylan 8a-f sl	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of W	hat Country?
th the Maryland Sa or 28a-f show s		9211 Spring Acres Road	20785		U	nited S	tates
with ms 3	uneral		. Was Decedent of His	spanic Origin? (Speci			e - American Indian, Black, e, etc.
death or ite	Fu	1 X Never Married 2 Married Armed Forces? 1 Yes 2XX No			can, etc.)		
s after	ý	Lor Dates:	Yes 2 X No		li deno	Specify:	B1ack usiness/Industry
2 hour	eted		ng most of working life		1)		nal Order of
36 Ibin 72 Gan Gan edical	nple		emarketer			Police	iai order or
6-00 ed will hygien other Me	Comple	17. Father's Name (First, Middle, Last)		18.Mother's Name (F			9)
21215-0036 und be filed within 7 Mental Hygiene. merked other toan e event, the Medica	Be	Anthony L. Brinston			lunter		
	۴		ailing Address (Stree				
, MD and 2 sho eath and cry 27 is			211 Spring sposition (Name of cer	melery.	ate		- City or Town, State
Baltimore, permit Pages I an Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory of	or other place)	Febru			
it Partmen ritmen y or c		4 Donation 5 Other Specify: RIVERDA 21. Signature of Funeral Service License Daniel W. Harrison	1e Cremato			Macon	ale Maryland
Ba perm Depa finjur			1661 good				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not en					
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Sharp Force Injuries					Death
xaminer		or condition resulting in death) Due to (or as a consequence of):					
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	nin	cause. Enter Underlying Cause (Disease or injury that initiated					
ed ssit	Examiner	events resulting in death) Last Due to (or as a consequence of):					
e executed ian and ial - transit	ical	d. VAMENDED # 1					
30, te be e	ledi	IF FEMALE: X AMENDED #1 per ME g90	00 2/22/10	TT		23d. Date o	f delivery
Box 68760, re death certificate be the attending physici red for use as the buri	cian/Med	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnanc	У	Month	Day Year
Box 6 e death ce the attend the attend ed for use	S.	4 Pregnant at time of death 5	Other (Specify)				
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the burn	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use cont	ribute to the cause of death?
P.O.	by				1 Yes	2 🗸 No 3	Probably 4 Unknown
of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by Juneral director, page 2 should be detach	ompleted				24a. Was		Were autopsy findings available
cor e law e has l	шb				autop	med?	prior to completion of cause of death?
of Vital Records, g Physician: The law requir ther this certificate has been s neral director, page 2 should	O	25. Was case referred to medical	26.Plac	e of Death (Check onl	1 Yes	2No	1 🗸 Yes 2 No
/ita /sicin nis cer	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa		Other Nursing H		Residence 6	✔ Other: Scene
Division of Vipial or Attending Physions after death. reral Director: After this filled in by the funeral di	\vdash	27. Manner of Death 28a. Date of Injury (Month Day Year)				now injury occur	
	ertification:	1 Natural 5 Pending Peb 6, 2009 1507 hr.	5 1	Yes 2 No	ubject stat	bed and cu	
Division tal or Attendi rs after death.	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office t				per or Rural Route Number, City
Division ospital or Attend hours after death. Internal Director:	Cen	4 V Homicide determined (Specify) Single Family				tate) d Road, Oxer	
Division of Vital I To the Hospital or Attending Physiciaus: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,		29a. Certifier (Cheek only one) Certifying Physician: To the best of my knowledge, death of one) Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, d	late and place, and dun, death occurred at the	ue to the caus he time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
To t with: To tl	Medical	and manner stated. 29b. Signature and title of certifier	29c. Licens				ned (Month, Day, Year)
		ill 1 1/N		.M.E.		February	
		30. Name and address of person who completed cause of death (Item 23a)					
Ra			11 Penn Street, E	Baltimore, MD 21	1201		
St	ate	31. Date filed (Month, Day, Year) 32. Registra's Sign Jure	,				
Regist	rar	FEB 12 2009 Cenera S. Jack				,	
DHMH 17 Rev 1/20	001	OCME ORIG	INAL				

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 02 2009 09 16:20 Wainwright Boseman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly Prince Georges Community Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1⊠M 2□F 70 Director 579-52-2030 02/07/1939 South Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo MD Prince Georges Upper Marlboro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20774 11502 Homestead Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: 2 3 Widowed 4 Divorced Black Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Media Specialist DC Public Schools 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental Alvin Boseman P Rosa Lee Ellis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. Upper Marlboro, MD 20774 Estella Boseman - Wife 11502 Homestead Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 02/16/2009 | Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cardiac Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Cerebral Infarct attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy this certificate 1□ Yes 2**X** No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ☐ ER/Outpatient 3 ☐ DOA 1 XX Inpatient Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Natural Injury 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier U053 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 Cheverly, MD 3001 Hospital Drive Berhane, MD Tsion State 31. Date filed (Month, Day, Year) FEB 12 2009

DHMH 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Rachael Louise Barron 242009 FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAURE DE GRALE HARFORT Home UTIZENS NURSING If Under 1 Year | If Under 24 Hrs. | 8. 8. Date of Birth 02-07-1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Pennsylvania 1 □ M 2 🖫 F 89 213-20-0974 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show a or 28a-f show be notified at 1 X Yes 2 □ No Director Maryland Harkord Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America "natural", or items 23a 98 Mount Royal Avenue 21001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Consumer Credit Lender Banking 12 should be filed w h and Mental Hygie 7 is marked other tl permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Barron Bessie Ankney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Mount Royal Avenue Aberdeen Maryland 21001 Tommy Morrison (nephew) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc 02/25/2009 West Chester, Pennsylvania 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Zelman Funeral Home, F.A. 21078 21. Signature of Taneral Service Licen 123 South WashingtonSt. Havre de Grace, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause or perch line. 23a. Part1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) remen's **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 m Month 5 ☐ Other (specify) signed by the a d be detached for I □ Yes 2 🗖 No o. 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending F 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident frer death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours Hospita 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

60

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien20091 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year CLARENCE UPTON BITTLE 250 PM 2009 Februay. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F 85 June 25, 1923 Mary land 218-30-8862 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 ☐ Yes 2 No Myersville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21773 3665 Bittle Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 N Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Grocery Clerk Grocery Store 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Undrue Grossnickle Daniel Bittle Daisy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Bittle-Wilson/daughter 3659 Bittle Road, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Mar.1, 2009 Smithsburg, Maryland 5 □ Other (Specify) inepal Service Licensee 4 ☐ Donation 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the viscouse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NOV. disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury

Physician /Medical Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it a Predict Exp. it at a rough once.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-transit Physician/Medical ed by the a detached for cate has been signed page 2 should be det Be Completed by certificate ! To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Certification: To

Division of Vital Records, P.O. Box 68760,

resulting in death) Last	Due to (or as a consequence of):
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown
	24a. Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? M 1 Yes 2 No

State Registrar

Medical

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only

106039

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jn P HEJ

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / Dep 1 - State Registrar Ce	artment of Health and M	lental Hygiei	7009 00130
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Herbert L. Bright		Month Februar	Day Year Year Year Y 21,2009 11:45 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Southern Maryland Hospital	Clinton If Under 1 Year If Under 24 Hrs.	O. Data of Dieth	Prince Georges
	Funeral		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday,	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	
	Director		244-16-2699 92 Yrs. Usual Residence of Decedent		Jan.18,	1917 NC
	how		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e Mares	Director	MD PG Forest			1 XYes 2 No
	ith th	Dir	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	eath wi	Funeral	1804 Benson Lane 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20747 Was Decedent of Hispanic Origin? (Sp.		nited States 14. Race - American Indian,
	r iten	ᇤ	4 This section of the	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
Š	ral",o	b	3 □ Widowed 4 □ Divorced 1941 − Year or Dates: 1945	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
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7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Evan Invernment burnfilled at		12 Comp	puter Specialist	e (First, Middle, Maid	overnment den Surname)
0	ld be ental ked o	To Be	Lee Bright	Bertha	Simmon	c
2	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene within 12 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is licalled Examinating to a collined at			ing Address (Street and Number or Run		
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5	0 ° + -		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ostyille, MD. 20 osition (Name of matory or other place)	Date 20c	. Location - City or Town, State
	permit. Pages Department of Important: If its any injury or o		4 Donation 5 Other (Specify) Cedar I	Hill Cemetery 3	/2/09 S	uitland,MD.
ם כ	permit Depar Impor any in		NO CO		-	Edwards F.H.
_	40 = 4 O		23a, Part Lenter the disease, or complications that caused the death. Do not er			uitland, Md. 20746 Approximate
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	1 1	or respiratory arrest,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	ylor Accide	4	
	Examiner		A H a CO SC / A O M	c Cardiovoscul	or Dice	45-8
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c			
Š	e exe sian a urial-t		resulting in death) Last Due to (or as a consequence of):			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d			
S	certifi Iding se as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
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ָ ט	ne law require has been si ge 2 should b	Completed	Chronic Obstructive Sulmonors	+ Disease	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The sate h	Con	Hupertension		performed	
2	ician: certifi ector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Other:	h (Check only one)	
5	Phys this al dir	: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Appatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing Ho	ome 5 Residence	e 6 Other (Specify)
5	ding h. After funer	tion	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	20d. Describe now i	njury occurred
2	Atten r deat sctor; by the	ifica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office		t and Number or Rural Route Number,
5	al or s afte al Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	rate)
	lospit hour unera		29a. Certifier (Check only (Ch			
	the H hin 24 the F mplete	Medical	one) and manner stated.			
	vit To		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
)			CO. Norma and address of norma who completed a superior of death (Norma)	Print) (1.5-5%	1/1/1/2	47-1
			30. Name and address of person who completed cause of death (Item 23a) (Type ULL & LLL T. O Paig & co 9 U.m.)	20077066 Print) 6/88 Oxon Oxon Hill,	1/2/1/20	ord to tol
J	Sta	te	Cd. Dute filed (Marth. Day Was)	var toll,	mo	60173
	Registr	ar	MAK UN COURS Shown B. for	all		

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dly	√		State Registrar 1. Decedent's Name (First, Middle, L.	aet)		Cer	tificate of	Death	2. Date of De	Reg. No	2009	3, Time of Death
	Physici /Medic		Bernard H. Cars	*					Month	Da	15, 2009	
	Examir		4a. Facility Name (If not institution, gi Baywoods of Anna	,			*	r Location of Death		4c	County of Dea	th Arundel
1	Funeral		5. Social Security Number 6.		e (In yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th a <u>y</u> , Year)	9. Bir	thplace (State or Foreign ountry)
	Director		177–26–5607 Usual Residence of Decedent		75 ₹	rs.			Oct. 1	5, 1	1933 Pe	ennsylvania
	e Marylan ia-f show	ctor	Maryland 10b. County Anne An	rundel	10c. City, Town	or Loc		nnapolis				10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	th with the 23a or 28 18t be ro	Funeral Director	10e. Street and Number 7101 Bay Front I	Orive	·		10f. Zip Code	21403		10g. Ci	U.S.A	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanirar must be redified at once.	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 December 2 If Yes, Give Year or Dates:	No		/as Decedent of H Yes, specify Cub □Yes 2, 2, 2, 2, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, Whit Specify: W	
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212	d withir giene.	Somp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	me. D	Profes			U.S	S. Naval	Academy
land	uld be filed Mental Hy rked othe tic event,	To Be C	17. Father's Name (First, Middle, Las Bird Clarence Ca					18. Mother's Name	e (First, Middle, e Hemph:		n Surname)	
Baltimore, Maryland 21215-0036	and 2 shoresalth and N 27 is maer trauma	•	19a. Informant's Name/Relationship Scott Carson/sc					and Number or Run es Drive			or Town, State, Maryla	
imore	Pages 1 annent of He ant: If item		20a. Method of Disposition 1 Burial 2 XX remation 3 4 Donation 5 Other (Spec		20b. Place of cemetery Baltimo	Dispos , crem ore	ition (Name of atory or other plac Cremato	cy 2/22	^{Date} /2009		ocation - City or timore,	Town, State Maryland
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Lice					ess of Facility Joh				
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused	the death. Do no						unapott	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Rev	sal t	-a.	ilure					Onset and Death 3 years
1	/Medical Examiner			,	a consequence of		nt dia	betes				10 years
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60,	be executed ician and burial-transit		that initiated events resulting in death) Last	c Due to (or as	a consequence of	f):						
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P.O. Box (To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 ∐No 9 ∐Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnand Other (specify) _	ey .			23d. Date of de Month	elivery Day Year
	uires that signed b	वि	Part II. Other significant conditions	contributing to death b	ut not resulting in	the un	derlying cause giv	en in Part I.	23e. Did t		1 /	o the cause of death?
ecor	e law req has beer e 2 shoul	Completed							24a. Was		24b. Were a	utopsy findings available completion of cause of
E H	sician: The certificate I rector, page		OF Was assa referred to modical	T					1 □ Yes	2 No	death? o 1 ☐ Yes	s 2□No
f Vit	hysicia this certi al directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatio	ent 2 ER/Out	patient	3 □ DOA Oth	26. Place of Deat			6 □Other (Spe	ecify)
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ıry 28b. Ti ı <i>y, Year)</i> In	me of jury	28c. Inju Wor M 1	ry at k? Yes 2 □ No	28d. Describe			
Divis	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	Sertific	3 ☐ Suicide 6 ☐ Could not 6 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farr c. <i>(Specify)</i>	m, stre	et, factory, office		28f. Location (City or Tox	Street ai wn, Stati	nd Number or R e)	ural Route Number,
	ne Hospit 1 24 hour ne Funera	Medical (29a. Certifier (Check only one) Certifying F	Physician: To the best aminer: On the basis of and manner st	of examination and	death l/or inv	occurred at the ti estigation, in my	me, date and place, opinion, death occur	and due to the red at the time,	cause(s date an	s) and manner and place, and due	s stated. e to the cause(s)
	To the within 7 To the 7 Comp.	M	29b. Signature and title of certifier	Beres	mo		29c. Licens	0 2 9 5	71		ate signed (Mont	th, Day, Year) 2009
	(O)		30. Name and address of person who Pavi B, Berc	completed cause of c	death (Item 23a) (1	Type, P	Print) Defens	e Hav.				1114
*	Sta		31. Date filed (Month, Day, Year) FFR 1 G	32. Registr	ar's Signature	/m	n Kal	, , , ,	-	/		L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiethe O. O.

		ľ	For State Registrar	State of Ma		partment of F e <i>rtificate of</i>			eg. No.	06190
	Dhunini		Decedent's Name (First, Middle, Las	t)				2. Date of Death		3. Time of Death
	Physicia /Medic		Anna Mae Car					February	23 200	09 3:45 A M
}	Examin	er	4a. Facility Name (If not institution, give			-	or Location of Death		4c. County of De	
			303 Coneflower D 5. Social Security Number 6. Se		(In yrs. last birthda		iamsport	8. Date of Birth	9.5	shington Birthplace (State or Foreign
	Funeral Director			□M XXF	79 Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 26, 1		Birthplace (State or Foreign Country) Mary Land
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar le-f sl	ctor	Maryland Washin	gton	Wi	lliamsport	•			1 Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	Country?
	s 23a	erai	303 Coneflower D	rive 12. Was Decedent B	Ever in II C 1		21795	acifu Vas ar Na	14 Bace A	SA merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 te marked other then "natural", or Items 23a or 28e-f show eny injury or other treumatic event, Ite Medical Examicat must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes XXN If Yes, Give Year or Dates:	lo	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 💥 o	Specify:	Rican, etc.)	Black, W	
20	72 ho	Completed	15. Decedent's Ed (Specify only highest grad		16a. De	cedent's Usual Occup	pation during most of work	ina	16b. Kind of Busine	
21	ithin 7.	nple	Elementary/Secondary (0-12)	College (1-4or 5	+) life	ve kind of work done . DO NOT use retire	d)	g		
72	filed withi Hygiene. other ther	Co	17. Father's Name (First, Middle, Last)			Housew	ife 18. Mother's Name	/First Middle A		ome
and	d be findal hed of	Be								
Maryland	2 should and Men le marke eumatic	7	Franklin George 19a. Informant's Name/Relationship (7	Murray Type, Print)	19b. Ma	iling Address (Street	and Number or Rura	Mae Be al Route Number,	City or Town, State	a, Zip Code)
	alth a alth a 27 le		Thelma Carbaugh-	Daughter	303	Coneflowe	r Drive W	illiamsp	ort. Mary	land 21795
ore,	as 1 a of He of He fitem		20a. Method of Disposition 1AXBurial 2 Cremation 3	•	20b. Place of Dis	position (Name of rematory or other pla	ce)		20c. Location - City	
<u><u>E</u></u>	Page ment ent: If ury o		' 4 □ Donation 5 □ Other (Specify		1		l l	6,2009 W	illiamspo	ort, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le eny injury or other tre		21. Signature of Funeral Service Licen	500	(PS Horrored Afour	rreferativ Hom	e, P.A.		+, MD 21795
			23a. Part Enter the disease, or composhock, or heart failure. List only	lications that caused	the death. Do not a					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	Acuto	Tacho	mic It	21 Ko		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
В	LAdillilei	<u>_</u>	Sequentially list conditions,	b. Due to lat as	a consequence of):					
	nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dus to (01 23 t	a consequence or _j .					
΄,	execunand and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					1
68760,	tificate be executed ig physician and as the burial-transit	edical		d						
	rtifica ng ph as th		IE EEMALE.							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	B □Ectopic pregnancy □ Other (specify) _	у		23d. Date of o Month	delivery Day Year
	that	by Ph	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Vital Records,	w requires that been signed be should be det	ed b	PayKinso	1) 01	12 ase,	COPD		1 ☐ Ye	s 2 No 3	Probably 4 DUnknown
ဝ၁	e law re has bee	Completed	· ·					24a. Was ar		autopsy findings available to completion of cause of
Æ.		Com						perform	ted? death	? es 2□ No
/ita	Physicien: Th r this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	Check only one	9)	
of	S S S	7	1 ☐ Yes 💸 No 27. Manner of Death	Hospital: 1 Inpatie			4 Nursing Ho	-/-	nce 6 Other (S)	pecify)
uo	ding (h. After funer	tlon	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time Injur	/ Wo	rk? Yes 2 □ No	28d. Destribe ho	w injury occurred	
Division	or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be	200. Flace of Hije	ury - At home, farm,	street, factory, office		28f. Location (Str	reet and Number or	Rural Route Number,
Ö	after after Dire d in b	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)			City or Town	, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physical Example 2 Medical Example 2	/sician: To the best of iner: On the basis of and manner sta	examination and/or	ath occurred at the til investigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner ite and place, and d	as stated. lue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tive of certifier	, ,		29c. Licens	se number	29	d. Date signed (Mo	inth, Day, Year)
)			I havid la	house		Das	63233		02/2	3/09
4	H-3	1	30. Name and ddress of person who d	completed cause of de	, 1	e, Print)	A 4		Kho	did , ,
			31. Date filed (Month, Day, Year)		WE HAC	DERSTUWN	1 MARIC	ALID ZI	140 M	iahmood M!
	Sta Registr		FEB 2 4 20		A. A.	face				

			Please	Type or Print in						•		
		4	For State	State of Mary		epartment of F Certificate of		Mental Hy		0000	0 - 7	0.0
	-		Registrar 1. Decedent's Name (First, Middle, La	st)		ertificate of	Dealli	2. Date of D		2000	3. Time of De	y y
Physi	ician dica		Verleine Hayward	1 Carl				Febru	arv	17, 2009	2:00 A	М
Exam		-	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat			. County of Deat		
no de porte de la company			Shady Grove Adver			Rockvi11		10.01.60		ontgomer		
Funera			5. Social Security Number 6. S	Sex 7. Age (In 1 ☐ M 2 [X]F	yrs. last birth	Months Davs	Hours Min.	(Month, D	ay, Year	Co	nplace (State or Fi untry)	oreign
Directo	or		229-18-4245 Usual Residence of Decedent		84 ^{Yr}			Aug 19	, 19	Z4 VIT <u>9</u>	inia	
yland how	١.		10a. State 10b. County	100	c. City, Town o	r Location					10d. Inside City L	
e Ma Ba-f s	3	5	MD Montgome	ery De	erwood						1 Tes 2	IVINO
with th	2	5	10e. Street and Number			10f. Zip Code			_	tizen of What Co	untry?	
eath v	Finoral Director	2	17904 Muncaster I	load 12. Was Decedent Ever	in U.S.	20855	Hispanic Origin? (S	Specify Yes or N	USA o-	14. Race - Amei	ican Indian,	
fter d	1	5	1 □ Never Married 2 ☑ Married	Armed Forces?		13. Was Decedent of I		to Rican, etc.)		Black, White	e, etc.	
If E 12 13-00000 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	3	2	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 💆 No	Specify:			Specify: Wh	ite	
72 hc 72 hc	Completed	מופר	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retire	oation during most of wo	rking	16b. k	Kind of Business/I	ndustry	
within ene. than	8		Elementary/Secondary (0-12)	College (1-4or 5+)		rvisor	u)		Nov.	spaper		
filed Hygi other ent, tl	2		17. Father's Name (First, Middle, Last	"	Bupe	TVISOL	18. Mother's Nar	me (First, Middle				
uld be Aenta rked tic ev	, F		Linwood Hayward				Grace Me	ritt				
and 2 should be filed within 2 saith and Mental Hygiene. n 27 is marked other than "ier traumatic event, the Med	'		19a. Informant's Name/Relationship			Mailing Address (Street					ip Code)	
and and lealth m 27		-	Darlene Tucker/da			904 Muncast	er ka. D	Date			Farra Chata	
ages 1 If ite or ot			20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State	cemetery,	crematory or other pla				ocation - City or		
partition of a land 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. I minoriant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	انه	-	4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice	7//	w. Arur	ndel Cremat			1	nton, M		
any any	once		Deve Ver t	Hollton	01251	Going home Beverly L.	Heckrot	on Serv	ice C1	erkevill	x /04 e MD 21	029
		1	23a. Part1. Enter the disease, or con shock, or heart failure. List only	aplications that caused the	death. Do no					OLIKO VIII	Approximate Interval Between	en
Physicia	n		Immediate Cause (Final disease or condition	A A Le 1	1450	enic Pu	Imonor	. Eder	MA		Onset and Dea	ath
/Medica			resulting in death)	Due to (or as a cor	nsequence of		lar Bra	3				
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oo, be exect cian and curial-tra	2	LYG	that initiated events resulting in death) Last	C. Due to (or as a cor	nsequence of)	:			-		*****	
icate be physicial the bur	2	2		d								
entifica ing ph	Mod	20	IF FEMALE:									
attendir for use	inci	r II y si ci al I/ Ivieu i cai	23b. Was decedent pregnant	23c. If yes, outcome pf pr	Fetal death	3 Ectopic pregnand	y			23d. Date of deli Month	very Day Yea	ar
the de	100	325	in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	4□Pregnant at time 9□Unknown	e or geam	5 ☐ Other (specify) _						
that ned by deta			Part II. Other significant conditions	contributing to death but no	t resulting in t	ne underlying cause giv	ven in Part I.	23e. Did	toba <i>cc</i> o	use contribute to	the cause of deat	th?
quires quires an sign		on D						1 🗆	Yes 2	Pro 3 □ Pro	obably 4 Unk	nown
law re	200	naiaidiiioo						24a. Wa	s an	24b. Were au	topsy findings ava	ailable
The ate ha	8	5						per 1□ Yes	formed?	death?	2 □ No	ie oi
iclan: Sertific ector,	0	מ	25. Was case referred to medical examiner?	Hospital:		Out		ath (Check only	one)			
Physical direction		2	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outp	atient SD BOA		Home 5 ☐ Res 28d. Describe		6 Other (Spec	cify)	
ding h. After	2		1 Natural 5 Pending 2 Accident investigatio	(Month, Day Yea		ıry Wo	rk?]Yes 2 ☐ No	Zod. Describe	now inju	ary occurred		
After r deat ector by the	1	2	3 Suicide 6 Could not be determined	90 Place of injuny	At home, farm	n, street, factory, office		28f. Location City or To	(Street a	nd Number or Ru	ral Route Number	r,
talor s affe al Dir	Cortification			building, etc. (5	респу)			City of Te	JWII, SIAI			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Modical			hysician: To the best of my miner: On the basis of exa and manner stated.								
To the vithin To the vomple	Mod	ME	29b. Signature and title of certifier	77	~~	29c. Licens	se number		29d. Da	ate signed (Mont)	n, Day, Year)	
, ,,,			* Man	\sim		Do	58025		Feb	uary 1	7 200	9
(3)00			30. Name and address of person who		A A	/pe, Print)	ve, Roci					
E	21 -		Jonathan Wenk 31. Date filed (Month Day, Year)	2- 9901 Me		ender Wir	ve, Koch	Kuille	Md.	20850		
Doc	State		SI. Date filed (Morito day, real)	anno La sulla - grature	had !							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, N 6800 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13, Month Year **Physician** HARRIET OZMAN CLARK Februari 05/5 AM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner albot Easton Memorial Hospita If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | MAR Month 3ay, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 218-30-2092 1 ☐ M 2 🛣 F 74 Months MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medicial Examinar must be notified at 1 ☐ Yes 2 No Director MD. TALBOT TRAPPE 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21673 6049 OLD TRAPPE ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: is marked other than "natural", or 1 □Yes 2★□No 21215-0036 Specify Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland and 2 should be fi CLAUDIA BAYNARD CHARLES E. OZMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any injury or other trau once. 6049 OLD TRAPPE RD. TRAPPE, MD. 21673 W. FRANKLIN CLARK/ HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHES. CREM. CTR. 2-15-09 STEVENSVILLE, MD. 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or 's a consequence of): disease or condition resulting in death) /Medical Examiner traabdom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 WNo 3 Ectopic pregnancy Day 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 Z No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes uspital or Attending Physician: Thours after death.

Ineral Director: After this certifical by filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Nnpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 2-13-2009 MD TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett 5. MD; Z 19 5. 10 Bennett 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 12, Physician 2009 Areta Crotts February 11:29 aM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 12100 Grandview Ave. Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🛣 F 213-24-3675 March 14, 80 Yrs 1928 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Woolcal Evancinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Wheaton MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 USA 12100 Grandview Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 YMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White <u>م</u> 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last Ida O. Sies Jesse David Webb, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12100 Grandview Ave., Wheaton, MD 20902 Perry L. Crotts / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 17, 2009 1 → Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 590 University Blvd. West, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 No page 2 should be detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 □No 1 ☐ Yes 2**X** No 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Matural
2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐No after death. investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0058095 February 13, 2009

State Registrar

Box 68760,

P.0.

of Vital Records,

Division

30. Name and address of person

31. Date filed (Month, Day, Year)

Tonya L. Hardy M.D.

10801 Lockwood Drive, Suite 205, Silver Spring, MD 20901

of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNA IANNIELLO CROPPER FEB 2009 1:41 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Director 578-32-3100 December 5, 1920 88 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt; If item 27 is marked other than "natural", or items 2.0 and 10 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11119 Lockwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: Specify ò 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 0 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Dominic Ianniello Esther Olivieri 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health a Important: If Item 27 is any Injury or other trau Brian Cropper - Son 4712 Hornbeam Drove, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Arlington National Cemetery 03/03/2009 Arlington, Virginia 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a july that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Division of Vital Records, P.O. certificate has been signed by the a rector, page 2 should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 🔽 No 1 □Yes 1 ☐ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation Injury To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D67974 NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 PARIZAD TORABI-PARIZI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 17 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes O O O

		1	For State Registrar/AMEND#31,SEE		Maryland	-	artmen <i>rtificat</i>			and M		giene Reg. No.	2009	06803
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	/Medic		4a. Facility Name (If not institution,	Frances Ag			4b. City.	Town, or	Location o	of Death	Februar		2009 County of Dear	
	Examin	er	Montgomery Gener		,		,,	,	01ney					gomery
	Funeral			. Sex 7	. Age (In yrs. las	t birthday)	If Under		If Under	24 Hrs.	8. Date of Bir (Month, Da	th	9. Bir	thplace (State or Foreign
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	D.	- +	Usual Residence of Decedent		- 170									
	show		10a. State 10b. County		10c. City, 7	lown or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2X No
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at once.	by Fui	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Ford	es? E⊠No		fYes, spec		Specify:	n, Puerto	ecify Yes or No Rican, etc.)		Black, White	
ŏ	2 hou	Completed	15. Decedent's	Education			dent's Usua kind of wo			t a f u a rlei		16b. Kin	nd of Business	
218	hin 7 e. an "n Med		(Specify only highest Elementary/Secondary (0-12)	College (1-4	for 5+)	life.	DO NOT us	se retired)	t Of WORK	rig			
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<u>ya</u>	Meni Meni arkec	၉	Lloyd	Jenkins							dred McI			
a	2 sho		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City or	Town, State, .	Zip Code)
2	and lealth m 27		Robert M. Crump, J	r Son								1 0,	Marylar	
o.	ges 1 t of H If itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from St	tate 20b. Plac	e of Dispo netery, crer	sition (<i>N</i> ar natory or o	ne of ther place	9)	L	ate	20c. Loc	cation - City or	Town, State
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Bal	permit Depar Impor any in		21. Signature of Funeral Service Lie			Н	2. Name ar ines-R 1800 N	inald	i Fune	ral H	ome, Inc	ver Sp	oring, Ma	ryland 20904
	Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final	ilv one cause on ea	ch line.				g, such as	cardiac o	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (o	r as a consequer	nce of):			DEI	VT				
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₽,09 <u>/8</u>	icate be executed physician and the burial-transit	dical Exar	that initiated events resulting in death) Last	c. Due to (o	NARY / ras a consequer ERTEN	nce of):	N	<i>>()</i>	-/1/26					- TO
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P.O. Box	ath cer attendir for use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	1 ☐ Live bi	ome of pregnance rth 2 Tetal do ant at time of dea wn	eath 3[Ectopic p		,			2	3d. Date of de Month	livery Day Year
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed									24a. Was auto perfo 1 □ Yes		death?	utopsy findings available completion of cause of 2 □ No
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of	Phys this	£	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ In		R/Outpatier Bb. Time o	nt 3 🗆 DO		7 110		me 5 Resi		Other (Spe	ecify)
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Ö	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the t					ne, date ar	nd place,			and manner a	s stated.
	the Hos hin 24 h the Fur npletely	Medical	(Check only 2 Medical E.	kaminer: On the ba	sis of examinatio		vestigation	n, in my o	pinion, dea			date and	place, and due	e to the cause(s)
	{V 5≱69	-	29b. Signature and title of certifier				290	D 3	783	30			e signed (Moni	13, 2009
	Ψ		30. Name and address of person w	LLY, 34	6 OLANI	WOOL	CT					208	32	
	Sta Registr		31. Date filed (Month, Day, Year) FERRUARY 13, 201		gistrar's Signatur		Bens	we	A.	fran	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 1730 Feb James Joseph Crowley, Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Rehabilitation + Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday lisburu Year If Under 24 Hps. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1X M 2□ F 81 218-20-3602 Nov. 17, 1927 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f shov Iner must be notified at 1 ▼ Yes 2 No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 414 Wilkins Street Funeral 21801USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examines and, 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electricals 12th electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည James Joseph Crowley, Sr. <u> Aileen Hitchens</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 White Street - Salisbury, Maryland <u>Kyle Crowley</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Salisbury Crematory 02/13/2009 Salisbury, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, M.D. 21. Signature of Funeral Service Licenses JOLLEY MEMORIAL CHAPEL 2180123a. Part1. Enter the disease, or complications that chused the death, shock, or heart failure. List only one cause of the line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0>1 1000 /Medical e (or as a consequence of Due **Examiner** 90m. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): signed by the attending physician defected by the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate has autopsy performed? res 2 \(\sum{\text{No}}\) 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tyes 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 UNatural 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ If ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

illiam

Loan

2000

29c. License number

vic Ave.

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robins, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2009 0744 awthorne 12 21 James ebruari /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner heMemorial Hospital Easton albot Year) 4 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min Country) 216-42-853 3 ug. 18,1 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or items 23a or 28a-f show, Injury or other traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No 9 albo hman death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Island Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify Black 3 Widowed 4 Divorced "natural" Completed Lawthorn 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Kestav shwa 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cawthorne ev ပ Dernice Snowden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a /67/ 19a. Informant's Name/Relationship (Type. Print) tilghman Island Rd, P.O. Box 160 Rosa TIGHMAN IS LAND
200. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. John Cemetery 4 □ Donation 5 □ Other (Specify) herwood, 22. Name and Address of Facility
HENRY FUNERAL HOME,
510 Washington St. 21. Signature of Funeral Service Licensee ge, MD, 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequen cate has been signed by the attending physician page 2 should be detached for use as the buria Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check online) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) one 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) memorial MD 21601 aslions 31. Date filed (Month, Day, Year) **FEB 18 2009** 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 06806 Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day MABEL CALDWELL 02-16-09 11:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death SOUTHERN MARYLAND HOSPITAL Prince George's Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F Months Days Hours Min. 71 Director 577-58-2874 Richmond, VA Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director Maryland Prince George's Fort Washington 1 TYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 USA Funeral 12120 Old Fort Road 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐Yes 2 【 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes → No Specify: δ 3 ™ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Switch Board Operator DC Government traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Mabel Hankins Joseph Nichols Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health au Important: If item 27 is any injury or other trauonce. 2983 Brinkley Rd. #T1 Temple Hills,MD 20748 Cheryl Caldwell/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1€ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Cedar Hill Cemetery 02-20-09 Suitland, Maryland 21. Signature of Funeral Service License MO1246 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 1 ac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner MUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed ysician and burial-trans Due to (or as O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ŪNo 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manuar of Death Date of Injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Suite Willinton, Mc State Registrar

State of Maryland / Department of Health and Mental Hygienes 06807 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Christine E. Coleman 02 2009 14:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner
 Washington Adventist Hospital

 5. Social Security Number
 6. Sex
 7. Age (In vrs.
 Takoma Park Montgomery 7. Age (In yrs. last birthday) If Und Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 K F Months Davs Hours Min. Director 09/12/1931 214-28-9665 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the modical Examination in the routhed at Director 1 Yes 2 No Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21076 7504 Saffron Court USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 21 No Specify. 2 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 6 Substitute Teacher D.C. Public Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daisy Yarborough ပ Walter Poge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Gaskins - Daughter 7504 Saffron Court Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 02/23/2009 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Electric the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Infarchion Examiner mypcardial Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) the detached 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ∐ Yes 2 ☑ Mo 2 🗆 No 1 □ Yes e Hospital or Attending Physician: 7 24 hours after death. e Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ 11/0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner 1 eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical pletely (Check only one) and manner stated. To the I within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)0060 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) niversely Metmina 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 06808 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Februar Day ZQ09 Physician 10 JOEL DEAN CASTLE /Medical 4b. City, Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Mata podica If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 - 31 - 1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 → M 2 □ F VA. 217-40-1161 Director 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Mudical Examiner must be notified at 1 □Yes 2X No MD. CHARLES WELCOME Directo 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 20693 U.S.A. 1225 HENSON LANDING ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify.WHITE <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DELANCY PRINTING 12th PRESS FOREMAN 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If item 27 is marked any linury or other traumatic ewores. Health and Menta em 27 is marked VELVIA DELOLA MARTIN JAMES ALBERT CASTLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 HENSON LANDING RD. WELCOME, MD. 20693 PAULA CASTLE-SPOUSE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEM.GARDEN 3-2-2009 WALDORF, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Mucho 23a. Part 1. Enter the disease, or complications to 12 used the shock, or heart failure. List only one cause of each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** anno Re /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed In ending physician and use as the burial-tran Due to (or as a Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown ģ signed d be det Part II. Other significant conditions contributive to death our not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ੬ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 \square No 1 ☐ Yes 2 ☐ No 1 ☑Yes 25. Was case referred to med examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) and manner stated. To the within 2 To the I 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Print) enter 7-C Post Office Rd Waldorf, MD 20602 State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 06809 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ALLEN JOSEPH CHESTER, SR. FEB.25 2:10P. M 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES 8. Date of Birth (Month, Day, 8-14-1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1√2 M 2□ F Days Hours Min. WASH., D.C. Yrs 61 Director 577-64-1169 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f show Director MD. CHARLES BRYANTOWN 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13230 CHELTENHAM PLACE 20617 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, filed within 72 hours after 1 Types 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√2 No Specify 2 Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR & C PEST CONTROL 12th and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be pe Pages 1 and 2 should ALFRED JOSEPH CHESTER BETTY JANE ALICE GATT 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 l LINDA CHESTER-SPOUSE 13230 CHELTENHAM PL. BRYANTOWN, MD. 20617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State permit. Pages Department of Important; If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD. VETERANS CEMETERY 3-6-09 CHELTENHAM, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee M00479 Whiche 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, ner Due to far as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year □Yes 2□No 5 Other (specify) o the detached 9 Unknown 9 Unknown 2 ۵. signed I be det Part II. Other significant, conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy Were autopsy findings available prior to completion of cause of death? has page 2 The certificate performed 1∐Yes 2DN 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to no examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 🔁 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death uneral Director: A sly filled in by the f 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medi and manner stated the within To the 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) woldorf.

State Registrar

DHMH 17 Rev 1/2001

Dr. Orgi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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er *	Funeral		2 Framingham Cour 5. Social Security Number 6.5		e (In yrs. las	t birthday)	if Under 1 Year	If Under 24 H	rs. 8. Date of Bi		ontgomery 9. Birthp	place (State or Foreign
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	death ms 23	Funeral Director	2 Framingham Cour	12. Was Decedent 8	ver in U.S.	13. \	Vas Decedent of H f Yes, specify Cuba	ispanic Origin?			14. Race - Americ	
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5	2 should be f and Mental I is marked of aumatic ever	욘	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin					or Town, State, Zip	Code)
Na Na	tra tra		Cristina Rivas/fr	iend		2 Fra	mingham (Court Ga	ithersbu	rg,	MD 20879	
o e	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐	Domewal from State	20b. Plac	e of Disponetery, cren	sition (Name of natory or other plac	e)	Date	20c. l	Location - City or To	wn, State
Daltimor	Pages tment of tant: If it		4 ☐ Donation 5 ☐ Other (Special	fy)	W. A		1 Cremato				nton, MD	
<u>8</u>	permit. Pages 1 am Department of Heat Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Lice	hisee' Off	3/07/0	G G	Name and Address Oing Home	e Cremat	ion Serv	ice	P.O. Bo	x 784
H		_	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused	MO12 the death.	Do not ente	eVerly L. er the mode of dyin	g, such as card	iac or respiratory a	rrest,	Iarksvilli	e, MD 21029 Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a		nce of):						
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o/00,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	•	d								
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Š	atten for us	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Fetal de	eath 3	Ectopic pregnancy Other (specify)	<i>y</i>			23d. Date of delive Month	ery Day Year
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5	/sicia	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2∏ EF	3/Outnatien	t 3 DOA Othe		eath (Check only o		6 ☐Other (Specif	
VISION OF	ig Phy ter this	n: To	27. Manner of Death	28a, Date of Injur	v 28	8b. Time of Injury	28c. Injury Work	y at	28d. Describe			<u>//</u>
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Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home :. (Specify)	e, farm, stre	eet, factory, office		28f. Location (City or To	Street a wn, Sta	and Number or Rura te)	l Route Number,
_	spital		29a. Certifier X Certifying P	hysician: To the best of	of my knowle	edge, death	occurred at the tir	ne, date and pla	ice, and due to the	cause	(s) and manner as s	tated.
	he Ho in 24 h he Fur pletely	Medical	(Check only 2 Medical Exa-	miner: On the basis of and manner sta	examination ted.	n and/or in	vestigation, in my o	pinion, death oc	curred at the time	date a	nd place, and due to	the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	10-		1	29c. License				ate signed (Month,	
						<u></u>	D3563	35		Feb:	ruary 18,	2009
((x1)02		30. Name and address of person who Joseph Kaplan, M.					uite 327	0lnev.	MD :	20832	
	Sta		31. Date filed (Month, Day, Year)	32. Pegistra	ır's Signatur	е			,			
	Registr	ar	170797	WINES COU.	a p	1. 18	ares					

09-01576

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Dayton		S ¹ 1- For State Registrar	tate of Maryland		artment o <i>rtificate o</i> :		d Mental Hy		eg. No. 2 (10	0 0601
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd	· ·				1.	2. Date of Dea	th	ل د	3. Time of Death
Weulcal Examili	ler	4a. Facility Name (if not institution	Lee Dayto			4b. City, Town, or I	ocation of Death	February :	23, 2009 4c. County of	Death	0815 hrs
		30430 Revells Neck r	oad			Westover			St. Mary's		
Funeral Director		5. Social Security Number 216-70-5423		ge (In yrs. I 49	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.		th(MM/DD/YYYY) 9/1959	9. Birl Foreig C	thplace (State or in lawyland
any	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locat	ion					10d. Inside City Limits
<u>*</u> .	_	Maryland Wic	omico	Sa	alisbur	У					1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	_	-		10f. Zip Code		1	0g. Citizen of Wha	it Cour	ıtry?
ith the Maryland 23a or 28a-f sho uotified at once											
15-0036 filed within 72 hours after death with the Maryland I Hygiene ed other than "natural", or items 23a or 28a-f ste	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								- 14. Race - White,		can Indian, Black,
after d	by Fu	3 Widowed 4 X Div	vorced If Yes, Give Year or Dates:	A No	1	Yes 2 X No		Specify:		white	
hours 'natur	ed	15. Decedent's Education (Spe	ecify only highest grade cor			nt's Usual Occupations of working life.			16b. Kind of Bus	iness/l	ndustry
36 hin 72 e than e	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	weld	der		1	weldi	na	
5-00; hed with Hygiene other t		17. Father's Name (First, Middle	,,				8.Mother's Name	(First, Midd.e, I	Maiden Surname)	.ng	1
6 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Donald A. Dayton Anne Marie Moll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town										
MD 21 2 should h and Me 27 is ma imatic ev	۲	19a. Informant's Name/Relationship (Type, Print) Donald Dayton/father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 1721 Emerson Ave., Salisbury, MD 218									
e, e, land I and Healt Healt item	İ	20a. Method of Disposition	2 🗆 🗆			ition (Name of cerr		Date	20c. Location - 3		
트 린 일 등 등 등 등		4 Donation 5 Other S	n 3 Removal from St	aic		Cremator	cy 2/3	26/09	Salisb	ury	, MD
Baltimor permit Pages Department of Important: If		21. Signature of Funeral Service	Licensee	mp	²² H	offoway	of Facility	Home Pr	ofession	a l	Association
Physician	\dashv	23a. Pan I. Enter the disease, or	complications that caused	the death		OT DITON I	I///	/ Dalio	Dur y / LID	210	Approximate Interval
/Medical xaminer		Immediate Cause (Final disease		rrhyt	hmia						Between Onset and Death
. 1		or condition resulting in death)	Due to (or as a cons	equence o	f):	liovacoul	ar dicor	350			
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons			uiovascui	ar disca	150	<u> </u>		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of	f):					_	
ecuted and transi			d	٦.		277 07	MT 0.0	N - 1 - 1 - 1 - 1 - 1	VO		
60, ate be executed hysician and e burial - transit	/ledical	X UNPENDED				PII,27,pe	rmE, gas	90 4/6/0			
68760, certificate be executed nding physician and sea sithe burial - transitive as the burial - trans	M/ug	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	me of preg		tal death 3	Ectopic pregna	ncy	23d. Date of d Month		Day Year
	Physician/N		4 Pregnant at	t time of de	m file	her (Specify)					
t the		Part II. Other significant condit	9 DIKHOWII	h but not re	esulting in the L	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use contrib	ute to	the cause of death?
ires that signed I be deta	함	Cirrhosis of						1 Yes	2 No 3	Prob	ably 4 🗸 Unknown
ords w requi	흵							24a. Was autop			topsy findings available ompletion of cause of
25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:											
of Vi	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,)		ER/Outpatient 28b. Time of I				Residence 6 🗸		Scene
- ± . ₹ ≥	틹	1 X Natural 5 Pend	ding	(ear)		1_ Ye	es 2 No				
Division ospital or Attendia hours after death. meral Director: y filled in by the fi	ertification:	3 Suicide 6 Coul	a not be	njury - At ho	ome, farm, stree	et, factory, office bu	ilding, etc.	28f. Location (S or Town, S		or Rur	ral Route Number, City
Dj ospital hours a meral I	ㅇ F	4 Homicide	rmined (Specify)								
Division To the Hospital or Attent within 24 hours after death To the Funeral Director	<u> </u>	(Check only Certifying P	hysician: To the best of m miner:On the basis of exa								
T To	ĕ├	29b. Signature and title of certifie	and manner stated.			29c. License	number		29d. Date signed	(Mor.	nth, Day, Year)
		hy his	, mas			O.C.N	1.E.		February 24	, 200	9
	Ī	30. Name and address of person Ling Li, MD Assista	who completed cause of o			t Raltimore A	MD 21201				
Sta	te	31. Date filed (Month, Day, Year)			re		- L L L L L L L L L L L L L L L L L L L				
Registr	-	FER 26	16	سه	B. Sa	which					

			For State Registrar	State of Maryland		artment of H			jiene _{eg. No} 2 0 0 9	06812
P	hysicia	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic	al	Reginald Val 4a. Facility Name (If not institution, give s	Davin		4b. City, Town, or	Location of Deat	February	7 13, 2009 4c. County of Deatl	7:30 P M
, E	xamın	er	St. Thomas More N			Hyattsvi		•	Prince Ge	
Fu	neral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			nplace (State or Foreign untry)
	ector		579-52-8055 Usual Residence of Decedent	83	Yrs.				, 1926 Wash	ington, DC
ryland	E No		10a. State 10b. County		, Town or Lo					10d. Inside City Limits
e Ma	Ba-f e	Director	District of Col	umbia Wa	shingt					1X Yes 2 No
with ti	a or 2	Dir	10e. Street and Number	1 C CT		10f. Zip Code			log. Citizen of What Co	•
death	ms 23	Funerai	4000 South Capito 11. Marital Status	12. Was Decedent Ever in U.	S. 13. \	20032 Was Decedent of Hi f Yes, specify Cuba		Specify Yes or No-	United Sta	rican Indian,
after	or Its	y Fur	1 Never Married 2 Married	Armed Forces? 117 Yes 2 ☐ No If Yes, Give		r Yes, specπy Cubai 1 □ Yes 21√2 No	n, Mexican, Puer Specify:	to Hican, etc.)	Black, White	e, etc.
1215-0036 within 72 hours after death with the Maryland	is marked other than "natural", or flems 23s or 28s-1 elow aumatic event, the Medical Examinat must be notified at	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:		dent's Usual Occupa				American
Maryland 21215-0036 d 2 should be filed within 72 hours af tth and Mental Hygiene.	Medic	Completed	(Specify only highest grade		(Give	kind of work done of NOT use retired,	uring most of wo	rking	160. Killd Of Businessyl	ndustry
d 21 filed witl Hygiene		Com	12 years	College (1-40137)	Supe	rvisor			Governme	nt
and Ibe	neven	Be	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
Should Mer	mark	ှ	Lawrence Davin 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a		Chase	r, City or Town, State, Z	in Code)
Mand 2	r trau		Tanya Davin - Dau		1				ngton, DC 2	
altimore, mit. Pages 1 er partment of Hee	r oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Dispo emetery, cren	sition (Name of natory or other place	9)	Date	20c. Location - City or	Fown, State
ti Pages	rtant: Jury c		4 ☐ Donation 5 ☐ Other (Specify)	Arl					Arlington	
Baltimore, Marylar permit. Pages 1 end 2 should be Department of Heelth and Menta	eny ir		21. Signature of Funeral Service License	No satis					neral Home	•
			23a. Part Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death	-					Approximate Interval Between
Pnys	ician		Immediate Cause (Final disease or condition	Arteriose	(eno	tec Cand	100-0	Ves Du	taise	Onset and Death
	dical niner		resulting in death)	Due to (or as a consequ			0,00			4
		ē	Sequentially list conditions bif any, leading to immediate	. Due to (or as a consequ	uence of):					
cuted	ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
760, te be executed	sicien and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):					
- ±	<u> </u>	dicai								
OX 6	ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna		-			23d. Date of deli	very
O. Box	ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certifics r death.	d by the	Phy	9 ☐ Unknown Part II. Other significant conditions con		ulting in the u	adorhina obuco aus	n in Part I	230 Did to	bacco use contribute to	the cause of death?
Records,	ld be	d by	Chrome Obs		-	i) 1+ease				obably 4 Unknown
aw re	s beer	Completed	Respirator	to - love	1/20	toTurs	-Acne	husta Was	an 24b. Were au	topsy findings available
F 5	ete he page	mo	-	0	V		13	perfo	med? death?	completion of cause of
/ita	ector.	Be	25. Was case referred to medical examiner?	on ital		Tou		ath Check only o		
Phys	rathis or	5 5	1 Yes 2 No	ospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time of	t 3 DOA Othe	4 Nursing F		ence 6 Other (Spec	uty)
ion nding	r: Afte e fune	ation	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Work	? ∕es 2⊡No	200. 5000.50	an injury socialist	
Division of Vital lor Attending Physician: after death.	recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Ton	treet and Number or Run, State)	ral Route Number,
Ospitel o	arel Di									
Div To the Hospitel or within 24 hours afte	To the Funerel Director: After this certificate hes been signed by the completely filled in by the funeral director, page 2 should be detached	Medicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examir	sician: To the best of my knower: On the basis of examinal and manner stated.	wledge, death tion and/or in	occurred at the time vestigation, in my op	e, date and place pinion, death occ	e, and due to the durred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
To the within 2	To th	Me	29b. Signature and title of certifier		\bigcap	29c. License	number		29d. Date signed (Monti	n, Day, Year)
	,		Bullen	Lewrelm	\checkmark	00	1850	2	FEBRUARY	18 2009
1-4			30. Name and address of person who co	Deutselan mpleted cause of death (Item NE MAS 422	23a) (Type,	Print)	ne. Rol H	lug tho	110 41/15	242/
	Sta	te	31. Date itted (Month, Day, rear)	32. Registrar's Signa	The second	1	7100	7 1/	-11-12-0	
J. F	Registr	ar	FEB 19 2009	central p. 1	The same of the sa					

Division of Vital Records, ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t completely within 2

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Cumberland od: 32. Registra Signature **ORIGINAL**

State Registrar

34

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrate D#23e, 24a/bperMD2-19-09, BMW, McC Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 Month Physician /Medical 1620 PM LBKAHIMI 2009 TOORAN FEBRUARY 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** 627-32-266 1 M 2 K **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10d Inside City Limits Ħ 1 Yes 2 No Funeral Director Gaithersbur traumatic event, the Medical Examiner must be notified MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 20878 15 A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status Race - American Indian. Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Miduit F 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Medical 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be EBRAHIMI ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or other traum. Bent MARYAM 162 Gaithersburg Daughter MD-20878 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State Park 02 Rockville 15/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Ser 22. Name and Address of Facility oedbridge VA. 22191 Easy Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Diffuse **Physician** alveolar hemorrhage 7 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner thromboutopeni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Evans ears syndrome the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical The law requires that the death certificate be use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Fibrosis 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Hospital or Attending Physician: The lav 24 hours after death.
Funeral Director: After this certificate has 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 📈 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1. Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral L 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) To the vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February MGOICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 6

31. Date filed (Month, Day, Year)

DHMH 17 Bev 1/2001

Johns Hopkins

32 Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb 16, Physician 2009 Ebanks Kenneth G. 5:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4505 Cedell Place Temple Hills Prince George's 9. Birthplace (State or Foreign Country)
West Indies If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 € M 2 □ F Yrs 093 46 3823 63 Feb 26, 1945 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the the dical Evanture. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □No Director MD P.G. Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4505 Cedell Place 20748 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify Afro- American Baltimore, Maryland 21215-0036 1 □Yes 2√√No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ebanks Morland Etta Wildman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Maddox (Wife) 4505 Cedell Place, Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 21, Date 2009 20c. Location - City or Town, State xXBurial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature if Funeral Service Licenses 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD M00257 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform page certificate 2 X No 1 □Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nursing Home 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continue of the date of the da 29a. Certifier

State Registrar DHMH 17 Rev 1/2001

Medical

(Check only one)

29b. Signature and title of certifier

Isaacs,

29d. Date signed (Month, Day, Year)

2009

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jole

32. Registrar's Signature

5801 Allentown Road, Camp Springs,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, ^{CP} To the Hospital or Attending Physician: The law requires that the death certificate be executed

		For State Registrar		State o	of Marylar		artment rtificate			and N	lental Hyg	giene Reg. No.	2009	06816
Physicia /Medic		1. Decedent's Name (First, Ethel Mae Fis)							2. Date of Dea Month February	Day	Year 2009	3. Time of Death 7:20а м
Examin		4a. Facility Name (If not ins	_				4b. City, 7			of Death		4c. 0	County of Death	1
Funeral Director		5. Social Security Number 206–26–5908 Usual Residence of Deced	6. Se.		7. Age (In yrs.	last birthday) 74 Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da July 16,	h y, Year)	9. Birth	nplace (State or Foreign untry) A
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Modical Evan net instituted at ones.	Completed by Funeral Director	10a. State 10b. 0 MD 1 10e. Street and Number 3400 Gleneag1 11. Marital Status 1 Never Married 23 3 Widowed 4 Direction 15. Dec. 1	county contgome contgom c	e Apt #2 12. Was Deconomic Armed For 1 Tyes, Ging Year or Decation	2H edent Ever in U orces? 2X No ive lates:	16a. Dece	Spring 10f. Zip 20	906 ent of His fy Cubar No	Specify:		ecify Yes or No- Rican, etc.)	1.	en of What Cou USA 4. Race - Amer Black, White, Specify: Wh.	ican Indian, etc.
Aental Hygien rked other th tic event, In	To Be Con	17. Father's Name (First, Andrew Gold		2		Но	memaken				e (First, Middle, Schell	Maiden S	Own Home Surname)	
Department of Health and I Important: If Item 27 Is ma any injury or other trauma ance.		19a. Informant's Name/Re Stephen Fis 20a. Method of Disposition 1	anich ation 3 \square Finer (Specify)	Husbar Removal from Entombr	State 20b. F	3400 Place of Dispo cemetery, crem te of He	Gleneacy sition (Nam natory or oth aven Ce	gles of the place	Drive,	Apt.	#2H, Si Date 19, 2009 eral Home est, Silve	lver S 20c. Loc Silve	Spring, Mination - City or Terring,	D 20906 Fown, State
nysician Medical kaminer pe prulal-transit	ical Examiner	23ar Part 1. Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions and the cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	e. List only or	Osteon Due to Stage Due to Advance	caused the deat cach line. myelitis (or as a conseq 4 Decubi (or as a conseq ced Senil (or as a conseq (or as a conseq	uence of): tus Ulce uence of): e Dement	ers				or respiratory ar	rest,		Approximate Interval Between Cnset and Death
y the attending p	hysician/Med	IF FEMALE: 23b. Was decedent pregns in the past 12 months 1 □ Yes 2 ☑ No 9 □ Unknown	arit j	1 Live	tcome of pregna birth 2 D Feta nant at time of a	il death 3 □	Ectopic pro					25	3d. Date of deliv	very Day Year
igne be d	Completed by Ph	Part II. Other significant c	onditions co	ntributing to d	eath but not res	ulting in the ur	nderlying ca	use give	n in Part I.		1 □ Y 24a. Was a autop perfor	es 2⊑ an	No 3 Pro	the cause of death? bably 4 1 Unknown opsy findings available ompletion of cause of
is certific	To Be C	25. Was case referred to n examiner? 1 ☐ Yes 2XXNo	-	lospital:	Inpatient 2	ER/Outpatier	nt 3 □ DO/	Othe	r.		h (Check only o	ne)		
after death. Director: After th in by the funeral	Certification: T	2 Accident 3 Suicide 6	Pending investigation Could not be determined	28e. Place	of Injury oth, Day, Year) e of Injury - At he ing, etc. (Speci	28b. Time of Injury ome, farm, stre ty)	М		at		28d. Describe h	ow injury	occurred	ral Route Number,
24 hours e Funeral letely filled	Medical Ce	29a. Certifier 1 🛣 Co (Check only one) 2 M	ertifying Phy edical Exami	ner: On the b	e best of my kno casis of examina ner stated.	owledge, death ation and/or in	n occurred a vestigation,	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
vithin To the	Me	29b. Signature and title of	nel	Vio 1	Bu.	SE 1	0	License					signed (Month)	
		30. Name and address of p	oblewski	L	1355 I	Piccard I	,	Rocks	rille,	MD 2	0850			
Stat Registra		31. Date filed (Month, Day, FEB 1	8 2009		Registrar's Signa	far	w							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 06817 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Day DUCHS GARET 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death IMRE If Under 24 Hrs. OF MARYLAND MEDICAL CENTER If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours Min 1 □ M 2 🙀 F 64 06-10-1944 170-34-9941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Md Prince Georges Yes 2□No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12303 Shadow Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2★☐ No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Sector Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Assistant 18. Mother's Name *(First, Middle, Maiden Surname)* Eva Stah1 17. Father's Name (First, Middle, Last) Harold 0chs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jenifer Samidad / Daughter Bowie, Md. 20715 12210 Raritan Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2009 4 □ Donation 5 □ Other (Specify) Atlantic Crematory Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie, Md Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) compu Spinal Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

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23a

items

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"natural"

alth and Mental Hygiene.
27 Is marked other than "r
r traumatic event, Inc. Med

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

the Medical Examiner must be notified at

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification: To

Medical

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

Hospital or Attending Physician: The law requires that the death certificate be executed and physician a attending pl icate has been si certificate funeral director, After t within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

P.O. Box 68760.

Division of Vital Records.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 Unknown

autopsy performed? Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

25. Was case referred to medical 1 Yes 2 □ No 27. Manner of Death

5 Pending investigation

1 Inpatient 28a. Date of Injury (Month, Day, Year, 104/09 6 ☐ Could not be

Hospital:

2 ER/Outpatient 3 DOA 28b. Time of Injury 30 P

28c. Injury at Work? 1 ☐ Yes 2 XNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

BACTIMORE MD 21201

29a. Certifier (Check only one)

1 Natural

3 Suicide

2 Accident

4 Homicide

Place of Injury - At home, farm, street, factory, office building, etc. (Specify) SHOPEING CENTERPARKING LOT 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) WALLETT CHARLETT, 3 GAMBRIUS MD 21054

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 GREENE ST

MEGAN BRENNER 31. Date filed (Month, Dav. Year

Registrar's Signature

510

State Registrar

Box 68760.

Paul B. Berez, MD 31. Date filed (Month, Day, Year)

FFR I

29b. Signature and title of certifier

2225 E Defense Highway 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D0029571

Crofton, Maryland

29d. Date signed (Month, Day, Year)

2/13/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Charles William FOLTZ 1630 M February 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 1 Year | If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) July 7, 194 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 X M 2 □ F 67 July 218-40-3944 1941 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Tyres 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Jefferson Street 21742 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 21 No Specify: Specify: white 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 concrete truck driver 0 concrete producer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ralph F. Foltz Mary Elizabeth Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Foltz - son 9617 Crystal Falls Drive, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Beaver Creek Cemetery 2/24/09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

the burial-transi and 68760, ed by the attending physician detached for use as the buria P.0. cate has been signed by page 2 should be detach Division of Vital Records, certificate funeral director, this After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Examiner Physician/Medical ģ Completed Be Certification: To filled in by the

1 Natural

2 Accident

4 Homicide

(Check only

29b. Signature and Itle of certifier

3 Suicide

29a. Certifier

5 Pending

investigation

6 Could not be determined

Physician

/Medical

Examiner

10a State

Funeral

Director

ir items 23a or 28a-f show

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, If a Medical Exx. app. nones.

1 and 2 should be filed within 72 hours after

Pages 1

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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31. Date filed (Month, Day, Year) State Registrar

Medical

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22911 Borhan

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

9-01286									
David	F	Fi	elds						

∕id E. Field	ls		For State	State	of Maryla	and / Depa <i>Ce</i>	artment of rtificate of	Health <i>Death</i>	and Me		R	leg. No	20	09 (0682	
Physi	ician		gistrar Decedent's Name (First								 Date of Dea Month 	Day \	Year	 Time of De 2103 hrs 		
dical Exa	mine		David Edw					l O'l Tay	vn, or Location		February	12, 2009	ty of Death		·	
		4a. Facility Name (if not institution, give street and number) 47 Chrisba Road							wn, or Location a Park	on or beaut			Anne Arundel			
		7 Ago (lo vre lest hirthday)						If Under	1 Year If U	nder 24Hrs.	8. Date of Bi	irth(MM/DD/YY	(YY) 9. Bir	thplace (State	or ·	
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any :			0a. State 10b. 0			10c. City	y, Town or Locati	on	10					10d. Inside C		
*		_	MD An	ne Ar	undel	S	everna 1	Park						1 Yes	Z XINO	
Maryland 28a-f show	at on	Directo	10e. Street and Number					10f. Zip C					Og. Citizen of What Country?			
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s after ral",	niner	<u>-</u>	Widowed 4 15. Decedent's Education		or Dates:		16a Deceder	t's Usual O	ccupation (G	ive kind of w	ork done	16b. Kind o		Industry		
hour	Ехап	ᇍ	Elementary/Secondary			(1-4 or 5+)	during m	ost of work	ng life. DO N	IOT use retire	ed)	Anne	Arun	del	•	
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215-0036 be filed within 72 hours after death with the Maryland milt Hygiens had warners", or items 23a or 28a-f sho	he M	Completed	17. Father's Name (First,	Middle, Las	st)							, Maiden Surn	ame)			
21215-0036 valle of the filed within 72 I Mental Hygiene.	ent, 1	å	Arden A. F				401 11 70		G	ail C.	Crews	umber, City or	Town Stat	e Zin Code)		
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene.	atic e	٩	19a. Informant's Name/R			77 - 1-3									- 1	
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Baltimore, permit Pages 1 ar Department of He	nt: II item 27 is in		1 Burial 2 X C	remation 3	Removal	from State A	tľantic	Crema	tory,	1 Peb	. 14, 009	Gler	n Buri	nie, MD		
timent fam	y or o	-	4 Donation 5 C	Other Speci	fy: ensee					acility	3 C-	verna l	Dowle 1		Homo	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a		į,	160		5 H	1ln	. 140	15 Gov	r. Rita	chie H	wv.Se	verna	Park.	MD 211	46	
Physici			23a. Part I. Enter the dis	ease, or cor	mplications that	caused the dea	ath. Do not enter	the mode o	f dying, such	as cardiac o	r respiratory	arrest, shock, o	or heart	Approxima Between	nterval Onset and	
/M_di	cal		failure. List only on Immediate Cause (Final		a. Contact C	Sunshot Wo	und of Head							De	ath	
amii	ner		or condition resulting in	death)	Due to (or as	a consequence	e of):									
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3876 rtifica	23b. Was decedent pregnant in the past 12 months? 1									Year						
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ds,	24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 26 Place of Death (Check only one)															
col	b b sprior to comple death? 1 ✓ Yes 2 No 1 ✓ Yes									No						
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Of \	After th funeral	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe now injury occurred													
On tendir	or: A	aţio	February Feb 12, 2009 1955 hrs										umber City			
ViSi or At	24a. 1 Vector in the law required to medical examiner? 1 Natural 5 Pending Investigation and selection in the law required to medical examiner? 25. Was case referred to medical examiner? 1 Ves 2 No 26. Place of Death (Check only one) 27. Manner of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Des 27. Manner of Death 1 Natural 5 Pending 1 Natural 5 Pending 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Des								or Tow	wn, State) ba Road, Severna Park, MD						
Spital																
Division of Vital the Hospital or Attending Physician: hin 24 hours after death.	To the Fun completely		29a. Certifier 1 Cer (Check only one) 2 Me	rtifying Phy dical Exam	iner:On the ba	sis of examination	vledge, death occ on and/or investig	ation, in m	y opinion, de	ath occurred	at the time, o	date and place	, and due to	the cause(s)		
To th	Certifying Physician: 16 the best of my knowledge, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29d. Date									signed (Month, Day, Year)						
	South State of the state of the						7	O.C.M.E.				Febru	February 13, 2009			
12.1	1	0	30. Name and address	of person v	vho completed	cause of deat ((Item 23a)	-								
B	سرو	V	Zabiullah Ali, N		ssistant Me	dical Exami	ner 111 P	enn Stre	et, Baltim	ore, MD 2	1201					
100			31. Date filed (Month, I	Day Year)	32	. Registrar's Sig	nature									

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 Arnold Roscoe Folks Feb 16, 9:55 P M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital $\begin{array}{c|ccccc} Clinton \\ \hline \textit{H Under 1 Year} & \textit{If Under 24 Hrs.} \\ \hline \textit{Months} & \textit{Days} & \textit{Hours} & \textit{Min.} \\ \hline \textit{Min.} & \textit{Feb 22,} \\ \end{array}$ Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1√2 M 2□ F 579 50 7003 70 Virginia 1938 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√1No P.G. Maryland Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4876 Longview Road 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold V. Folks Edna Polk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20604 Mildred M. Soper (Sister) 14290 Poplar Hill Road, P.O. Box 1882, Waldorf, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb 23 Date 2009 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature July ral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

09

20735

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exercities managed.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran certificate has been signed by the rector, page 2 should be detached nours after death.

Ineral Director: After this centre of illed in by the funeral director.

 $\mathcal{HAQ}_{\mathcal{C}}$ (Marks) Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 24a. Was an autopsy 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X ANatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

within 24 ho

To the Function

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malekanian, Favzad, 7503 Surratts Road, Clinton, MD

FEB 18 2009

31. Date filed (Month, Day, Year) State

32. Registrar's Signature Eneway.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year 11:00 pM Susan Angela Gunnulfsen February 2009 /Medical 16 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 13616 Autumn Trail Drive Germantown Montgomery Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🖾 F Director 577-96-0645 46 April 4, 1962 District of Columbia Usual Residence of Decedent 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exercine, must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v Funeral 13616 Autumn Trail Drive 20874 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: by Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Pre-school Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 0 Eugene Battista Jennifer Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A. Gunnulfsen - Husband 13616 Autumn Trail Drive, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 02/21/2009 Brentwood, Maryland 21. Signature of Funeral Service Linens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Nonce 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immedi L e (Final dise le or condition resulting in death) Onset and Death **Physician** Metastatic Breast Cancer year+6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Be Completed page 2 should 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 No certificate 1 □Yes 2 🗆 No 1 Tyes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No hin 24 hours after deat the Funeral Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 7 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D37236 February 17, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.B. 6410 Rockledge Drive, Suite 506, Bethesda, MD Carolyn Hendricks 31. Date filed (Month, Day, Year) 3. Registrar's Signature State FEB 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 06824 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 20, 2009 Medical Examiner 1130 hrs Ralph Gordon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Hours Director 578-74-4325 53 05/30/1955 1**X** M 2 Country) Usual Residence of Decedent 10c. City, Town or Location any 10d. Inside City Limits 1 X Yes 2 No n/a D.C. Washington death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5616- 13th Street, N.W. 20011 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 X Never Married 2 Married Yes 2 X No Yes, Give Year Widowed Divorced Specify: Black Yes 2 X No specify: <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) be filed within 72 is marked other than atic event, the Medical 21215-0036 t Pages I and 2 should be filed within imment of Heavil and Mental Hygiene reaut: If item 27 is marked other than yor other transmatic event, the Medic, Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses G. Johnson Sarah Bell Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Carver Johnson/Brother 26 East 6th St. #603 Cincinnati, Oh. 45202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Important: It crematory or other place) Burial 2 X Cremation 3 Removal from State Riverdale Park 3/2/09 Riverdale, Md. Other Specify: Donation 5 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. ature of Funeral Service License w 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interva failure. List only one cause on each line. Between Onset and /Medical Death aAcute coronary artery thrombosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Atherosclerotic cardiovascular disease Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed sician/Medical PI line a-b, 27, perME, $g889 \ 3/6/09 \ TT$ attending physician or use as the burial -XUNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 | Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Records, P. Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Hospital: Other4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 this Residence 6 ၉ 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Yes 2 No Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 21, 2009 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

3. Registrar's Signature

		For State Registrar	State of Mi	arylanu / L		ificate of L		i Wentai i t	Reg. No	0000	06825
Physicia	an	1. Decedent's Name (First, Midd						2. Date of D Month	Da		3. Time of Death
/Medic	al	Ruby J. Gun				4b. City, Town, or	Location of Dea	02	13	2009 County of Deatl	10.55
Examin	er	Holy Cross Hos				•	Spring		2.5	lontgome	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hi Hours Mi	s. 8. Date of B			nplace (State or Foreign untry)
Director		551-30-5181	1 □ M 2 🖾 F	89	Yrs.	Dayo		02/10/			xas
and ow		Usual Residence of Decedent 10a. State 10b. County	y	10c. City, Town	n or Loca	tion					10d. Inside City Limits
Mary -f sho	ţō	MD Princ	ce Georges	Co1	1606	Park					1 X Yes 2 □ No
or 28g	Director	10e. Street and Number	ocorgeo.	002		10f. Zip Code			10g. Cit	tizen of What Co	untry?
ath wi	ral [4904 Muskogee				207				USA	
er de	Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces? rried 1 ☐ Yes 2 🛣		13. Wa	as Decedent of Hi es, specify Cuba	ispanic Origin? n, Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Amei Black, White	
urs aft	þ	3 X Widowed 4 ☐ Divorce	If Yes Give		128	Yes 2□No	Specify:			Specify: Wh	ite
72 hou	Completed	15. Decede	nt's Education est grade completed)	16a.	(Give kir	nt's Usual Occupa	furing most of w	orking		ind of Business/I	ndustry
han "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	`life. DC	O NOT use retired)			eral Gov	ernment riculture
filed w Hygie ther t		17. Father's Name (First, Middle	, Last)			Editor	18. Mother's N	ame (First, Middl			riculture
ld be lental ked o	To Be	Clarence Alfr					G1 adv	s Hunt			
shou and M s mar	-	19a. Informant's Name/Relation		19b	. Mailing	Address (Street a			ber, City	or Town, State, Z	(ip Code)
and 2 ealth n 27 th		Doris Barbour	- Daughter			luskogee		ollege P			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Notical Eventher must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 ☐ Removal from State			tion (Name of tory or other place		Date		ocation - City or	
t. Pag rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify)	Ft. Li		n Cremat				twood,	
permi Depar Impo any ir		21. Signature of Funeral Service	1	atlan)1 Blade					ome, Inc. 20722
		23a, Part 1, Enter the disease, of	complications that cause	d the death. Do							Approximate Interval Between
Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	st only one cause on each li								Onset and Death
/Medical		resulting in death)	a. Hypote Due to (or as	a consequence	of):						<u>-</u>
Examiner	_	Sequentially list conditions.		genic Sh							
ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2	a consequence		C					
execut execut and and al-trar	xan	that initiated events resulting in death) Last	0.	atic Ova		Lancer					
tificate be executed g physician and as the burial-transit	edical		d								
		IE EENALE.							T		
eath cert attendin	/sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12_months?		2 Fetal death		Ectopic pregnancy	у			23d, Date of deli Month	very Day Year
the dei	ysic	1 □ Yes 2 🔼 No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 ∐ (Other (specify)					
that the the the the the the the the the th	/ Phy	Part II. Other significant condit	tions contributing to death b	out not resulting in	n the und	erlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
quires n sigr	d by							_ 1□	Yes 2	No 3□ Pr	obabiy 4 ☐ Unknown
aw rec	Completed							24a. Wa		24b. Were au	topsy findings available completion of cause of
hysician: The Is his certificate ha I director, page 2	E O							per	opsy formed? 2 No	death?	2 No
cian: ertific ector,	Be (25. Was case referred to medic examiner?				I au		eath (Check only	one)		
Physical this call dire	မ	1 Yes 2 No 27, Manner of Death	Hospital: 1 ☑ Inpati 28a. Date of Inj		utpatient Time of		4 LI Nursing	Home 5 Re			cify)
dlng h. After funer	tion	1 X Natural 5 ☐ Pend		ay, Year)	Injury	28c. Injun Work	Yes 2∐No	200. Describe	e now mju	ry occurred	
Atten r deat sctor: by the	ifica	3 Suicide 6 Could		jury - At home, fa tc. <i>(Specify)</i>	ırm, stree	et, factory, office		28f. Location	(Street al	nd Number or Ru	ral Route Number,
al or all or all or all Dire	Certification:	4 ☐ Homicide deter	building, e	ic. (Specify)				City of Ti	own, State	*)	
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendire completely filled in by the funeral director, page 2 should be detached for use		(Check only 2 Medice	ring Physician: To the best								
thin 2,	Medical	one) 29b. Signature and title of certifi	and manner si	tated.		29c. License	e number		29d. Da	ite signed (Monti	n. Dav. Year)
F.¥ 5 8		255 Signature and title of certific	11/				305		٦	11410	9
0 1/		30. Name and address of perso	n who completed cause of	death (Item 23a)	(Type, Pr		2005			1110	(
R16		Dr. Nabila Kh	an Holy Cro	ss Hosp	ital		rest Gl	en Rd S	ilve	r Spring	, MD 20910
Sta		31. Date filed (Month, Day, Yea	r) 32. Regist	rar's Signature	1						
Regist	rar	FEB 1 9 2009	CEANA P P	1900							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

P.0. of Vital Records, Division or Attending within 24 hours after death. filled in by Hospital completely

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

State

Baltimore, Maryland 21215-0036

Box 68760,

Registrar DHMH 17 Rev 1/2001 30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print)

John Stuckey, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

Registrar's Signature

1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D23649

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 16, 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Denise Marie Hearing 8:55 A M February 16, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Gaithersburg Wilson Healthcare Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours Min. 1 M 2 F DC 03/15/1924 84 579-20-8839 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 United States Apt. 508 407 Russell Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertin Cassou Germaine Companion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent J. Hearing / Husband 407 Russell Ave. #508 Gaithersburg, MD 20877 ce of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemet 13/27/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral 5130 Wicsonsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an breastons 2 🖪 No 1 ☐Yes 25. s case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760.

Funeral

Director

show

Pages 1 and 2 should be filled within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It. Nwdfcal Evan is a must be notified at

Department of H Important: If ite any injury or ot

Physician

/Medical Examiner

burial-transi

the t attending pl

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached : After this certification funeral director, [within 24 hours after death.

To the Funeral Director: A completely filled in by the fu within 2. 2

> State Registrar

Certification: To

Medical

1 Tes 2 TNo

5 Pending investigation

6 ☐ Could not be determined

N. Robert berschipe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

04115

28d. Describe how injury occurred

201 RUSSELL AVENUE GAITHERSBURG MAD 20077

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:50 2 2009 Vearl Anne Hutchinson 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice of Timonium Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F Days Hours Director <u> 220-36-0340</u> 8-14-1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ellicott City r than "natural", or items 23a or 28a-f st Fre Madical Exprehen must be nutified Director 1 ☐ Yes 2 St No MD Howard 10e. Street and Number 10g. Citizen of What Country? 3218 Hearthstone Rd. 21042 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 2 1 □Yes 2√2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Daily Anna M. Brauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry R. Hutchinson / Husband 3218 Hearthstone Rd., Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t Removal from State 4 □ Donation 5 □ Other (Specific) 2-23-2009 Marriottsville, MD Crest Lawn Mem. Gdns. 21. Signature of Funeral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Par 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician UTERINE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🛣 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2**K** No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: ieral Director: After this certific filled in by the funeral director, 24 hours a

To the within 2

86

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

JACKIE JONES, CRNP 31. Date filed (Month

(Check only 2 Medical Examiner: On the basis of example) X Nurse Practition Perestated.

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar #18, TCHD, 02/12/2009. TLS Amended, #17. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** EBRUARY 9 2009 KOSE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number 6. Sex STERTOWN 24 Hrs. 8. Date of Birth HOSPITALC KEN 8. Date of Birth (Manth, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕏 F Months Days Hours Min 75 227-38-0184 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location must be notified at Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/6/ UST 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No Completed by If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker Grason Ville other traumatic event, 17. Father's Name (First, Middle, Last) George Stewart 18. Mother's Name (First, Middle, Maiden Surname) Be 🚄 Anderson ည monac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 617 Centreville MD Warner aughte 2 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie grunce 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Frem /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

I blirectorath.

I blirector After this certificate has been signed by the attending physician and I blirector. After the page 2 should be detached for use as the burial-transit 045 tructure Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown trestutechen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital

filled in by

To the Hospital within 24 hours a To the Funeral I completely TLS

Medical

State Registrar and manner stated.

29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

Black

1 Yes 2 No

29b. Signature and title of certifier 29c. License number 066371

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 Brown Street Charter to

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

22. Registrar's Signature

31. Date filed (Month, Day, Year)

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

			For State Registrar	State of	Marylan	•	artment of H rtificate of L		and Me		jiene eg. No. 2	009	06830
	Physicia	an	1. Decedent's Name (First, Middle, I						1	2. Date of Dea Month Februar	Day	Year 2009	3. Time of Death 5:10 a M
	/Medio Examin		Jeanette Sally 4a. Facility Name (If not institution, g	give street and num	iber)		4b. City, Town, or Bethesda			rebidai	4c. Co	unty of Death	
~	Funeral Director		Suburban Hospit 5. Social Security Number 6 485-32-7394		7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. 8 Min.	8. Date of Birth (Month, Day) 3 / 0 7 / 1		<u> </u>	lace (State or Foreign
	th the Maryland or 28a-f show	Director	Usual Residence of Decedent	mery		y, Town or Lo	10f. Zip Code			1	0g. Citizer	of What Cour	0d. Inside City Limits 1 Yes 2 No ntry?
9500-6121	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than "natural", or item ust be indiffied at a Madical Exercipation and the indiffied at	by Funeral	7420 Westlake Te 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest)	12. Was Deced Armed For 1	dent Ever in U. ces? 2 📉 No e	162 Dace	20817 Was Decedent of Hi If Yes, specify Cuba 1 □Yes 2 No dent's Usual Occup.	Specify:			Sp	US. Race - Americ Black, White, o pecify: of Business/Inc	ean Indian, etc. White
N	led within tygiene. her than '	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, La	College (1- 4	4or 5+)	1	kind of work done of DO NOT use retired ner/Office	e Man	ager	(First, Middle, i	Serv	sh Soci ice Age	al ncy
Baitimore, Maryiand	nd 2 should be filed alth and Mental Hyg 27 is marked other r traumatic event,	To Be	Jacob Siegel 19a. Informant's Name/Relationship			19b. Maili	ng Address (Street a	Sar	ah So	mit			Code)
re, Ma	2 3 E 2		Lewis Gerald Hul			7420	Westlake psition (Name of matory or other place	Terr		710, Be	ethes		20817
aitimo	permit. Pages 1 Department of I Important: If ite any Injury or of once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Synatur N Final Structure Lie	cify)		lean Me	emorial Go 2. Name and Addres Edward Sag	dns				, Maryl	and
	cate be executed of the burial-transit of th	Examiner	23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aorti Due to (c b. Cardi Due to (c c. Atria	c Aneut or as a conseq	h. Do not en Eysm uence of): est uence of):	ter the mode of dyin	ville	Pike	, Rock	ville	, Maryl	Approximate Interval Between Onset and Death 1 hour 1 hour years
P.O. BOX 58/50	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown		irth 2 ☐ Feta ant at time of o	I death 3	☐ Ectopic pregnanc; ☐ Other (specify)	у			23d	d. Date of delive	ery Day Year
	The law requires that the diate has been signed by the page 2 should be detached	þ	Part II. Other significant condition Chronic Anticoas	_	ath but not res	ulting in the u	inderlying cause give	en in Part I		1 🗆 Y	es 2⊡Ki	No 3□ Prot	he cause of death?
Vital Records,	The lar ate has bage 2	Completed								24a. Was a autopoperfor 1 Tyes	med? 2⊠No	24b. Were auto prior to co death? 1 □Yes	psy findings available mpletion of cause of 2 \(\sum \) No
Division of Vil	Attending Phys sr death. ector: After this by the funeral dir	Certification: To Be	25. Was case referred to medical examiner? 1 1 2 Yes 2 No 27. Manner of Death 1 3 Natural 5 Pending investiga 3 Suicide 6 Could no determin	28a. Date of (Monta	of Injury h, Day, Year)	28b. Time of Injury	Worl	er: 4□ Nu	ursing Hom 28 No	8d. Describe h	ence 6 ow injury of		iy) al Route Number,
_	Hospital Hospital Funeral tely filled	edical Ce			asis of examina		th occurred at the tire						
b	To the To the Comple	M	29b. Signature and title of certifier				29c. Licens	e number	27			signed (Month, ruary 13	
	Sta		30. Name and address of person w Dr. Kelly Cowen 31. Date filed (Month, Day, Year)	, 1201 Se	ven Lo	cks Ro		ille,	Mary	yland	20854		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 8-35AM Ruth Ermalee Heath February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Ceci1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🖸 F Director 103-32-1079 March 6,1932 Virginia 76 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 27 No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 1953 Blue Ball Road 21921 United States 23a Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Your Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 0 1 □ Yes 2 No Specify 2 3 ☐ Widowed 4 ☐ Divorced Specify: White natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 73 th and Mental Hyglene. 7 Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+ Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Ray Maude May Jackson ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Gary W. Heath / Son 1953 Blue Ball Road, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State February 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23, 2009 Rush Creek Cemetery Meadowview, Virginia 22. Name and Address of Facility Crouch Funeral Home Service Licensee 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran and certificate be execu Due to (or as a consequence) the attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 mont Month Day Year 5 ☐ Other (specify) P.O. 1 Tyes 2 DNe 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Division of Vital 1 Yes 1 ☐ Yes 21110 2 □No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐ Yes 2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npietely (Check only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 9 2009 Registrar

			For State Registrar	State of Mary	-	artment of l rtificate of			giene Reg. No. 2 () (06832
			1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic		Augustus Robe	rt Hobbs				February		
Man Control	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	ath	4c. County of	Death
and the			Peninsula Regiona	medical C	enter	Sall	sbury		Wica	nico
	Funeral		5. Social Security Number 6. Security Number 12	7. Age (In M 2 □ F 76	yrs. last birthday) Yrs.	Months Days	Hours Mir	n. (Month, Da	ıv, Year)	9. Birthplace (State or Foreign Country)
	Director		217-30-8856 Usual Residence of Decedent	/ (0 1101			Jan. 12	, 1933	Pennsylvania
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-fsh	ctor	Maryland Worceste	r	Berlin					1 □Yes 2KINo
	or 28)ire	10e. Street and Number	<u>, , , , , , , , , , , , , , , , , , , </u>		10f. Zip Code			10g. Citizen of Wh	at Country?
	23a	ral	10822 Maple Court			218			USA	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Medical Evaninar rout be notified at	Funeral Director	11, Walital Glatas	 Was Decedent Ever Armed Forces? 		Was Decedent of If Yes, specify Cub	Hispanic Origin? ban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race Black,	- American Indian, White, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 105 If Yes, Give 195 Year or Dates:	3-1961	1 □Yes 2 🛛 No	Specify:		Specify:	Black
21215-0036	tural	ed	15. Decedent's Edu	cation	16a. Dece	edent's Usual Occu	pation		16b. Kind of Busi	
712	in 72 in "in Modi	plet	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wed)	orking	Beauty	Shop
21	d with	Completed	Elementary, secondary (6 12)	2	self-e	employed			Deauty	
p	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Surname))
yla	ould I Men Tarke	ပ္	Theophilus S. Hobbs					A. Corbin		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to confire a subject.		19a. Informant's Name/Relationship (7)	•					er, City or Town, S	tate, Zip Code)
e,	1 and Heal tern 2		Mary Alice Hobbs/s 20a. Method of Disposition			Z Maple osition (Name of matory or other pla		in, MD 21		tity or Town, State
Baltimore,	ages ent of ht: If it		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Qepation 5 ☐ Other (Specify)	temoval from State			- 1	/21/2009	Berlin, N	Maryland
₹	artiti. F		21. Si nature of Funeral Service Licens	1						Salisbury, MD
m	Depar Impor any ir once.		* allucial	1. Salles	л Ј	OLLEY M	EMORIA	L CHAPE	Ĺ	21801
П			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	ications that caused the ne cause on each line.	death. Do not en	nter the mode of dy	ring, such as card	iac or respiratory a	rrest,	Approximate Interval Between
5	Physician		immediate Cause (Final disease or condition		white					Onset and Death
أكمدن	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):					
	Examine	_	Sequentially list conditions,	Depto for as a so		MACOG	= Suliner	u'n		
	nsit	nine	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dec 10 (01 as a 60	rissquarios orj.					
<u> </u>	execu n and lal-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
8760,	icate be executed physician and the burial-transit	dical		d						
9		Medi	IF FEMALE:						1	
Вох	death certifi e attending d for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of po 1 ☐ Live birth 2 ☐		☐ Ectopic pregnar	ncy		23d. Date Mont	of delivery th Day Year
0.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5	Other (specify)			I I I I I I I I I I I I I I I I I I I	ar Bay 10an
σ.	uires that the de signed by the a id be detached f		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	underlying cause g	iven in Part I.	23e. Did	tobacco use contrib	oute to the cause of death?
of Vital Records,	The law requires that the ate has been signed by th bage 2 should be detache	d by						1 🗆	Yes 2⊡No 3	B ☐ Probably 4 ☐ Unknown
S	w requir	ete						24a, Was	an 24b. W	ere autopsy findings available
Re	The law cate has page 2 s	Completed						 auto perfo 	psy pr prmed? de	ior to completion of cause of eath?
ta		BeC	25. Was case referred to medical				26. Place of D	1 ☐ Yes		□Yes 2□No
Ž	Physician: this certific ral director,	To B	examiner? 1 □ Yes 2 ☑ No	lospital:	2 ER/Outpatie	ent 3 DOA	ther: 4 \(\sum \) Nursing	Home 5 ☐ Resi	idence 6 Other	(Specify)
0		ino	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ar) 28b. Time (of 28c. Inj	ury at ork?	28d. Describe	how injury occurred	d
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				⊒Yes 2 □No			
Division	i ji te	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st Specify)	treet, factory, office		28f. Location (r or Rural Route Number,
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phy	sician: To the best of m	y knowledge, dea	ath occurred at the	time, date and pla	ace, and due to the	cause(s) and mar	nner as stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	(Check only 2☐ Medical Exam one)	iner: On the basis of exa and manner stated.	amination and/or i	nvestigation, in my	opinion, death or	ccurred at the time	date and place, ar	nd due to the cause(s)
	To the To	M	29b. Signature and title of certifier			29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
	-11/11		12	>		1-1	00561	57	2/16/0	35
	NEW	-	30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type	, Print)			7	
	V		31. Date filed (Month, Day, Year)	ompleted cause of death	Signature	mull St	SALUTY	, MD 21	801	
	Sta Registi		FEB 17 20	09 Janua	D. A	barre				

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 1- For 2/19/2009 State of Maryland / Department of Health and Mental state Amended item#20a, 20b. Date, 20c Certificate of Deathword, SLU 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harrel 02 Saac /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner HOSPICE OASTAL AT The Lake SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1**X** M 2□ F Months Days 227-40-7925 Director Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experient, ust be unified at Yes 2 No Director MD WICOMIC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21826 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) moloy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOKKS Savage Unknow ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Kd Michae Windsor Mi Burkley 20b. Place of Disposition (Name of Direct Crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If its any Injury or o oooce. 1/21//09 Dover, Burial 2 Cremation 3 ☐ Removal from State DE, 4 ☐ Donation 5 ☐ Other (Specify) TUFICA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arcenoma **Physician** URRI disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) been signed by the should be detached 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has page 2 s autopsy performed? certificate 1 ☐Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOS pile 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of funeral 27 Manner of Death 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 Da Natural ours after death. neral Director: Af filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier l 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30 ame and a press of person who completed cause of death (Item 23a) (Type, Print) M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Ma		epartificate of		vientai riyg F	leg. No. 2009	06834
	Physicia	an	1. Decedent's Name (First, Middle, La Toni Ha	,				2. Date of Dea	th Day Year	3. Time of Death 11:05 PM
1	/Medic	al	4a. Facility Name (If not institution, gi			4h City Town o	r Location of Death		y 08, 2009	<u></u>
Ì	Examin	er	National Instit		alth		thesda		Montgo	
	Funeral				(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		579-66-1022 Usual Residence of Decedent	3	9 Y	is.		APRIL 1	2 1949 WAS	HINGTON, DC
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar Ba-f s	Director	DC		WAS	SHINGTON, DC				1X Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Code	020		log. Citizen of What C	ountry?
	ns 23	Funeral	1920 U PLACE S. I	12, Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cubi		pecify Yes or No-	USA 14. Race - Am	
Maryland 21215-0036	permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Eventium of the Indifficult at Once.	by Fur	1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1√DYes 2 □ No If Yes, Give Year or Dates:	0	If Yes, specify Cuba 1 □Yes 2X No	an, Mexican, Puerto	Hican, etc.)		te, etc. BLACK
15-0	"natu	Completed by	15. Decedent's E (Specify only highest g	ducation rade completed)	1 (Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of work	king	16b. Kind of Business	s/Industry
12	withir iene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	ECHNICIAN	<i>4)</i>		GOVERNMEN	Т
פֿע	al Hyg other vent,	Be C	17. Father's Name (First, Middle, Las	t)	1		18. Mother's Nam	e (First, Middle,	Maiden Surname)	
ylaı	Duld b Ment arked	은	STANLEY E. HAWK				MARGUER			
, Mar	and 2 sh ealth and 27 is m er traum		19a. Informant's Name/Relationship EDDIE KELSEY/H		19	Mailing Address (Street 20 U PLACE	S.E. WASI		-	Zip Code)
Baltimore,	ges 1 if of Ho or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State		Disposition (Name of crematory or other place		Date	20c. Location - City o	
Ħ	iit, Pa artmer ortant: Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	ify)	FT. LI	NCOLN CEMET			BRENTWOOD, KINS FUNER	
Ba	Dep Impo		12/2						R, MARYLAND	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each line	the death. Do no	ot enter the mode of dyi	ng, such as cardiac	or respiratory an	rest,	Approximate Interval Between
-	Physician	3	Immediate Cause (Final disease or condition resulting in death)	_a C	evvico	11 canc	ev			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				
	P +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter bindenying Cause (Disease or injury that initiated events	b Due to (or as a	consequence of):				
	ecute and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or se s	consequence of	١٠				
68760,	tificate be executed g physician and as the burial-transit			bue to (or as a	consequence of	<i>j</i> •				
	± 0, @	ledical		u						***
O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Б		23d. Date of do Month	elivery Day Year
ď.	s that gned b e deta	by Pr	Part II. Other significant conditions	contributing to death bu	t not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ord	equire een si	ted						1 🗆 Y	es 2□No 3□F	Probably 4 Unknown
Vital Records,	The law requires t tate has been signe page 2 should be o	Completed						24a. Was a autop perfor	sy prior to med? death?	
ta			25. Was case referred to medical	1			26. Place of Dea	1 □Yes	2 No 1 ☐ Ye	s 2 No
<u></u>	Physician: r this certific ral director, I	To Be	examiner? 1 □ Yes 2 █ X No	Hospital:	nt 2 🗀 ER/Out	patient 3 DOA Oth	OF!		ence 6 ☐ Other (Sp	ecify)
o uo	Attending Ph r death. ector: After th by the funeral	tion:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Ti Year) In	ury Wor	ryat k? lYes 2 □ No	28d. Describe h	ow injury occurred	
Division of		Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farr (Specify)	n, street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	e Hospital or 124 hours afte e Funeral Dir letely filled in	Medical (29a. Certifier (Check only one) 1 CertifyIng F	Physician: To the best of aminer: On the basis of and manner star	examination and	death occurred at the to	ime, date and place opinion, death occu	, and due to the cred at the time, o	cause(s) and manner date and place, and du	as stated. le to the cause(s)
	To the within 7 то the сопри	Me	29b. Signature and title of certifier	121.	•	29c. Licens	se number		29d. Date signed (Mor	th, Day, Year)
	2-10		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T		70 1 1		reprucing	0 2009
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	10 Center	Dr., Bet	hesda, M	D 20892	
	Registr		FEB 1 2 2009 A	was N. 1	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Richard Michael Hughes State of Maryland / Department of Health and Mental Hygiene 2009 06835 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Medical Examiner Richard Michael Hughes 1241 hrs February 23, 2009 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 136 Broadway Avenue Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Min Director Hours 219-68-0238 1 X M 2 51 Nov. 12, 1958 Country) Maryland Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No must be notified at once, Maryland Washington Hagerstown the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 136 Broadway Ave. 21740 U.S.A. items 23a with Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 X Married , 10 1 X Yes Give Year White Widowed Divorced Yes 2 X No specify. Specify "natural" ò 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Wealth and Mental Hygiene ant: If item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than "traumatic event, the Medical 21215-0036 Maintenance Property Rental 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Lynnwood Hughes æ Emma May Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Kathleen L. Hughes 234 N. Potomac St. Hagerstown, Maryland 21740 (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date or other crematory or other place) Burial 2 XCremation Removal from State February Smithsburg, Maryland ment o Smithsburg Crematory 2009 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Atherosclerotic cardiovascular disease associated Death Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): With cardiomegaly Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated WS Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED 23a, PII, 27, perME, g889 3/23/09 TT XUNPENDED ending physician use as the burial Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic obstructive pulmonary disease Yes 2 No 3 Probably 4 ✔ Unknown 9 Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available alcohol abuse autopsy prior to completion of cause of certificate has performed? death? page Yes 2 ~ 2 25. Was case referred to medical 26.Place of Death (Check only one) director. Be examiner? Hospital: Other, ER/Outpatient DOA Inpatient 2 Nursing Home 5. Residence 6 V Other: Scene this 1 V Yes ٩ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Pending Yes 2 24 hours after death. Funeral Director: the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal To the within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 24, 2009 7 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed // 32. Registrar's Signature State

OCME 2006

State of Maryland / Department of Health and Mental Hygiene 06836 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 **Physician** 12:55 P M 2009 February Marion L. Hartman /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frostburg Village Nursing Home Frostburg
If Under 1 Year | If Under 24 Hrs. A11egany

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 💢 F Yrs. 86 June 5,1922 Cumberland, Director 235-30-0668 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r then "netural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Mineral Keyser Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 500 Carskadon Lane, Apt. 304 26726 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Retail Clothing other then Efementary/Secondary (0-12) Coltege (1-4or 5+) Proprietor & Buyer Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any linjury or other traumatic event 9DBS. Be Robert Shapiro Esther Cohen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marsha Paitsel/Daughter Rt. 4, Box 119-S-2 Keyser, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, State 20a. Method of Disposition Feb. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD The Cumberland Crematory 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home Mun 85 S. Main Street Keyser, WV 26726 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stag **Physician** 2 6 months disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The taw requires that the death certificate be executed use as the burial-transit ettending physician and I for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Heav est tail 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → 10 this certificate hes 1□ Yes 2No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No death. To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A investigation completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00055325 worsock Feb 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD21502 BISHOP WALSH WONSOCK SHIN 925 31. Date filed (Month, Day, Year) 32. Registral's Signature State Registrar

3

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

2 should be detache		contributing to death but not	resulting in the underly	ring cause	given in Part I.		co use contribute to the cause of death? No 3 Probably 4 V Unknown	
page 2 should be ompleted	-					24a. Was an autopsy performe		
etor, 1	25. Was case referred to medical				of Death (Check	only one)		
o B	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2 🗸	ER/Outpatient 3	ng Home 5 Residence 6 Other:				
the funeral director, page ation: To Be Com	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury		ry at Work? Yes 2 No	28d. Describe how	injury occurred	
filled in by the fun Certification	3 Suicide 6 Could not b	e 28e. Place of Injury - At h	nome, farm, street, fact	28f. Location (Stre or Town, State	et and Number or Rural Route Number, Cit e)			
completely filled in by the	29a. Certifier (Check only one) Certifying Physicial Certifying Physicial Certifying Physicial Certifying Physicial Certifying Physicial Certifier (Check only one) Wedical Examiner:		-			at the time, date and place, and due to the cause(s)		
Z Z	29b. Signature and title of certifier	-		29c. License number			d. Date signed (Month, Day, Year)	
	A AR. Hou	nell		0.0	M.E.	F	ebruary 23, 2009	

ORIGINAL

s of person who completed cause of death (Item 23a)

Assistant Medical Examiner

. Registrar's Signature

Pamela E. Southall, MD

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Natalie Joan Intrater 7:26 February 15, 2009 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Voar Months 1 □ M 2√57F 79 Aug 12, 1929 Director 104-22-1551 NY Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No MD Director Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 6701 Melody Lane 20817 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify White Specify ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F is marked oth æ .dry.
. 1 and 2 should be "Health and ""
.m 27 is Albert Block ပ May Auerbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Intrater /Son 2310 Evans Drive, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important; If its any injury or o once. 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Alexandria, VA 4 Donation 5 ☐ Other (Specify) Metropolitan Crematory Feb 17, 2009 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21, Signature of Funeral Service Licensee 500 University Blvd W, Silver Spring, MD 20901 23a. Part Y Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracranial Hermorhage disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, it accesses to the conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ending physician and use as the burial-transit Cerebrovascular Accident Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

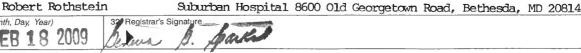
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for i Month Day Year 5 Other (specify) I∐Yes 2₺No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Dementia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 ☐Yes 2 🖾 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XX Yes 2 ☐ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F s after death. I Director; After d in by the funera 5 ☐ Pending investigation 1 XNatural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 I Homicide 24 hours a Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

30. Name and

18



ress of person who completed cause of death (Item 23a) (Type, Print)

115/69

ntrater, Natalie

D34179

February 15, 2009

)9-01248 Florence Emma		Amend Trem 5 per th.g889.U3/20/U9dnb	Are Legi giene	ble. inf.,g890	,04/13/09dhb
Physicia Medical Exami	ın/	1 Decedent's Name (First, Middle Last)	Reg. Date of Death Month February 11		3. Time of Death 1532 hrs
()		4a. Facility Name (if not institution, give street and number) E/B Route 328 4b. City, Town, or Location of Death Denton		4c. County of Death Caroline	thplace (State or Foreign
Funeral Director	į	5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 220-03-34-70 1 M 21 F 87 Yrs. Usual Residence of Decedent	11-20-	Co	untry) ryland
ind Show any nce.	٦	Md. Caroline Denton		1	10d. Inside City Limits 1 X Yes 2 No
the Maryla Sa or 28a-f	Director	10e. Street and Number 1021 Gay Street 21629		USA	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene and tritien 27 is marked other than "matural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 X Married Never Married 2 X Married Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:	Rican, etc.)	White, etc. Specify: Bla	
72 hours a n "natura al Exami	8	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wording most of working life. DO NOT use retired during most of working life.		16b. Kind of Business	
15-0036 filed within 7 Hygiene. d other than the Medica	91	12 Line Worker 17. Father's Name (First, Middle, Last) Robert Henry Young Florenge		Poultry aiden Surname) mmond	Factory
2121 nould be fill d Mental I is marked fic event,	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship (Type, Print)	ural Route Numb	er, City or Town, Stat	
Baltimore, MD 21215-003 oemit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingmy or other traumatic event, the Med		Leroy Sampson/Grandson 11155 Peppertree 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	Plata, Ma. 20c. Location - City o Goldsbo	r Town, State
Baltimore, permit. Pages 1 at Department of Het Important: If ite injury or other it		4 Donation 5 Other Specify:	nnie S	mith Fune	eral Home
Physician /Medical xaminer		23a. Part I. Enter the disease, or complied thins that cause! the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Mulitple Blunt Force Injuries Due to (or as a consequence of):	respiratory arres	st, shock, o r hea rt	Approximate Interval Between Onset and Death
ed .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
), be executed ician and inial - transit	a	UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. After this certificate has been signed by the attending physician npletely filled in by the funeral director, page 2 should be detached for use as the burial	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	ncy	23d. Date of delive Month	ry Day Year
P.O. Bc es that the des signed by the s	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		pacco use contribute t	o the cause of death?
ecords, P.O. ne law requires that the te has been signed by tge 2 should be detach	Completed		24a. Was a autops perform	med? prior to death?	
Vital Recc ysician: The lav his certificate ha director, page 2	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin		Residence 6 ✓ Oth	er: Scene
Division of Vital Records, rat or Attending Physician: The law require rate creath. The rate been simple to be the funeral director, page 2 should be in by the funeral director, page 2 should be	on: To	1 Ves 2 No Impater 2 Errodipater 3 500 4 No. 27. Manner of Death 1 Natural 5 Pending Feb 11, 2009 1528 hrs 1 Yes 2 No.	28d. Describe h	ow injury occurred ruck collision	or. Good of
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the t	Certification:	4 Homicide	or Town, St E/B Route 328	tate) 8, Denton, MD	Rural Route Number, City
the Hosp ithin 24 ho the Fune	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
TLS	Me	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (h	
6		30. Name and address of person write completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		
S Regis	tate stra				
DHMH 17 Rev 1/	2001	ORIGINAL		OCM	ie.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 4 2009 2340 Johnson Oliver Chruary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death New Prince Georges Haven Drive Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 7 / 2 8 / 1 9 5 4 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 1 X M 2 □ F Yrs. DC 579-72-0929 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4001 New Haven Drive 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hinnant Etha Haywood Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Johnson/Wife 4001 New Haven Dr., Bowie, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/20/09 Landover, Md Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2019 Martin Luther King Ave., Wash., DC Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Non Small ma WITH D e to (or as a consequen of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▼No 24a. Was an 2 No 1 ☐ Yes

Physician /Medical Examiner

physician and s the burial-transit

attending properties for use as

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he Hospital or Attending Pin 24 hours after death.
he Funeral Director: After the pletely filled in by the funera

To the within 2

page 2 s has

Completed

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Certification: To

Medical

requires that the death certificate be executed

The law i

Physician: : After this certification funeral director, p

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a. State

Md

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown à

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

Baltimore MD

27. Manner of Death 1 🔀 Natural 2 Accident 3 Suicide

4 🗌 Homicide

5 Pending investigation 6 ☐ Could not be

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier

1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 145931 29d. Date signed (Month, Day, Year) 2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avenue Dr. Dobbio

32. Registrar's Signature

31. Date filed (Month, Day, FEB 18 2009

09-01383 Willie Jones Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

'illie Jones	1- For State	State of	Maryland / D	Departi Certifi	ment of He icate of De	aiin an ath	u Menta	rrygierie	Reg. No.	200	9 0681
Physician/	TITTI	e (First, Middle,Last)	JONES					2. Date of D Month Februar			Time of Death 1743 hrs
ledical Examiner	4a. Facility Name (i	if not institution, give s				ty, Town, or	Location of D		4c. Co	ounty of Death	3
Funeral Director	5. Social Security N 239-60-0		7. Age (I	In yrs. last	birthday) If L	Under 1 Year onths Day	ar If Under 2	Min.	1	/YYYY) 9. Birthi	
wany	Usual Residence of				wn or Location	EIGHTS	5				1 Od. Inside City Limits
with the Maryland ns 23a or 28a-f show any be notified at once eral Director	10e. Street and Nu 6317 SE					Zip Code			10g. Citizer USA	n of What Count	ry?
or items 23a or must be notif	11. Marital Status 1 Never Marri	ied 2 X Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 X	ver in U.S.	If Yes, s	ecify Cuba	in, Mexican, P	? (Specify Yes or uerto Rican, etc.)		Race - America White, etc.	an Indian, Black,
2 hours afte "natural". **Lexaminer sted by	3 Widowed	ducation (Specify only	Yes, Give Year or Dates: highest grade comple College (1-4 or 5+)		6a. Decedent's Us during most of	sual Occupa f working lif	e. DO NOT us	nd of work done se retired)	16b. Kin	d of Business/In	
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exat		(First, Middle, Last) JONES				RPENTI	18.Mother's BESS	Name (First, Midd	e, Maiden Su IEL		
MD 2121 d 2 should be fil th and Mental I in 27 is marked numatic event.	19a. Informant's N BESSIE	ame/Relationship (Typ		11	6317 8	EAT F	LEASAN		CAPITO		Zip Code) 20743 MARYLAND
Baltimore, MD 2 pe mit Pages I and 2 shou D partition of Health and N In portant: If item 27 is n innery or other traumarite	20a. Method of Dis 1 X Burial 2 4 Donation 5	Cremation 3 Other Specify:	Removal from State	e cre	nce of Disposition matory or other p MONY CEM	lace) IETERY		2/23/200	9 LAN	DOVER,M	ARYLAND
Balt pe mit De pert In port	- Lu	uneral Service License			7474	LANI	OVER R	J. B. J OAD LAND	OVER,M	1ARYLAND	
Physician 'Medical aminer	23a. Part I. Enter t failure. List or Immediate Cause or condition result	//	cations that caused the hine. Multiple Sharp Foundation of the hind in the hi	orce Inju		ode or dyin	g, such as car	urac or respiratory			Between Onset and Death
Jen	Sequentially list of if any, leading to it	onditions, b immediate D	ue to (or as a conseq				183				
outed and ransit Examine	(Disease or injury events resulting in	that initiated C.	ue to (or as a conseq	quence of):							
te be executed ysician and burial - transit	UNPENDEI		AMENDED 23c. If yes, outcome	e of pregna	ancv				23d.	Date of delivery	
ox 6876 ath certificat attending ph or use as the	23b. Was deceden past 12 month	nt pregnant in the	1 Live birth 4 Pregnant at ti 9 Unknown		2 Fetal o	(Specify)	3 Ectopic	pregnancy	-	Month E	Year Year
P.O. Bc es that the designed by the a detached for the detached for the a by the a b	â	nificant conditions	contributing to death	but not res	sulting in the unde	rlying caus	e given in Par			No 3 Prot	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.								1	Vas an autopsy performed? 'es 2 No	prior to death?	topsy findings available completion of cause of es 2 No
of Vital F Physician: er this certific ral director, i	u 25. Was case refe	_	ospital: 1 Inpatien	ot 2 1	ER/Outpatient 3	_	Tour	Check only one) Nursing Home 5	Resider	nce 6 🗸 Othe	r: Scene
n of Viding Physical Control of the		2 No eath	28a. Date of Injur (Month, Day Ye FOUND:	ry ear)	28b. Time of Injur		njury at Work? Yes 2	28d. Desc	ribe how injurance assaulted	ry occurred	
Division pital or Attend ours after death teral Director: filled in by the	1 Natural 2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inju	jury - At hor	1739 hrs me, farm, street, f	actory, offic	e building, etc	or To	wn, State)	nd Number or Ru Drive, Capitol	ral Route Number, City Heights, MD
id Spi		Certifying Physicia Medical Examiner	an: To the best of my On the basis of exam and manner stated.	y knowledge mination an	e, death occurred d/or investigation	, in my opir	ion, death occ	ce, and due to the curred at the time,	date and plac	ce, and due to tr	ne cause(s)
	29b. Signature ar	nd title of certifier				1	ense number C.M.E.		- 1	Date signed (Mo	
R 5	30. Name and ad	ddress of person who do	completed cause of de nt Medical Exam	eath (Item :	^{23a)} 111 Penn Stre	eet, Balti	more, MD	21201			
Stat Registra		onth, Day, Year)	32. Registrar	r's Signatui	e Kal						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 8:45 ам 2009 Theodore Kliman February 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□ F Pennsylvania Director 182-24-4847 October 26, 1929 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examina is use to collect traumatic event, the Medical Examina is use to collect traumatic. 10a, State 10b. County 1 ☐ Yes 2 🖾 No Director Maryland Prince George's Greenbelt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 58-L Crescent Road 20770 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify Specify: þ 3 Widowed 4 Divorced Caucasian Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Artist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fay Tagen ဂ Joseph Kliman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important; If item 27 any Injury or other th Andrew Kliman - Son 60 West 76th Street, Apt. 4E, New York, New York 10023 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2009 4 □ Donation 5 □ Other (Specify) Mt. Lebanon Cemetery Adelphi, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm de Cause (Final disease or condition resulting in death) **Physician** Amyloidosis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Convestive Heart Failure Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Pneumonia and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical Colorectal Cancer the as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No ned by the 9 Unknown 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐Yes 2 🖾 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of erso

Adaku Onukogu, M.D.,

who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road, Silver Spring, Maryland 20910

D65953

February 16, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 10a-f, per FH g890 4/15/09 GS/TT State of Maryland / Department of Health and Mental Hygiene 06844 Reg. No. 2 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William KAPLAN 9:00 P M 2009 February 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Montgomery **Examiner** Chevy Chase 5630 Wisconsin Ave., #707 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 84 578-22-1729 Washington, DC 15, 1924 **Director** Aug. Usual Residence of Decedent 10a. State Florida 10c. City, Town or Location 10d. Inside City Limits Palm Beach Department of Health and Mental Hygiene. Important: If items 23a or 28a-f show Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantral russ be notified at any Injury or other traumatic event, the Medical Evantral russ to notified at any once. death with the Marylar Boca Raton Yes 2 7 Chevy Chase Directo Montgomery Maryland 10e. Street and Number 19674 Waters End Dr. #1002 10f. Zip Code 33434 10g. Citizen of What Country? 20815 5630 Wisconsin Ave., #707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 MYes 2 No If Yes, Give WW II Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Residential Developer 18. Mother's Name (First, Middle, Maiden Surname)
Leah Francis 17. Father's Name (First, Middle, Last) Be Joseph Kaplan 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Branchwood Court, Baltimore, MD 21208 Robin Kaplan, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King David Memorial Garden 02/19/09 Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Fun a vervice Lice 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician meumom /Medical Due (or as a consequence of): Examiner SPIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day 5 Other (specify 1 ☐ Yes 2 ☐ No the s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Fell Avg & 2008 0300 M 1 ☐Yes 2 ☐No 78 0 m within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 25 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 56 50 LUISCONS 4 Homicide 4 Chase Mb 20515 home AV Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the to the cau (s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the to the cau (s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) To the I 29b. Signature and fitte of 29c. License number 29d. Date signed (Month, Day, Year) February 17, 2009 D 13818 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary P. Fisher, M.D., 5530 Wisconsin Ave., Suite 700, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

FEB 18 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G889 3/05/09 Jh State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2009 Martha Lee Kelly 8 23:31 February 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number 8074 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Months 245-52-1938 70 12/22/1938 South Carolina Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Prince George's Maryland | Mt. Rainier 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4513 31st Street 20712 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Malichi Lee Relio McGill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4513 31st Street, Mount Rainier, MD Gene Kelly - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Harmony Memorial Park 2/14/2009 Landover, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) onen All to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23d. Date of delivery Day Month use contribute to the cause of death? □ No 3 □ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral Director

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. M. Mcdical Examples any once.

Baltimore, Maryland 21215-0036

Examine

Physician/Medical

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Be Completed

Medical Certification: To

29a. Certifier

and burial-trar within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	1	23d. Date of deliver
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the
		24a. Was an autopsy prior to competitive death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 \(\subseteq \text{Yes} \) 2 2
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ☐ 140	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred

3 ☐ Suicide 6 ☐ Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of

29c. License number

29d. Date signed (Month, Day, Year)

31. Date-filed (Month, Day, Year)

State Registrar

within 2

09-01539 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Travis Kusztos 06846 2009 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day February 21, 2009 1654 hrs **Medical Examiner** Travis Nicholas Kusztos

4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3562 Pinecone Circle Waldorf Charles 9. Birthplace (State or 7. Age (In vrs. last birthday) If Under Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY 5. Social Security Number 6 Sex **Funeral** Months Davs Hours Min Country) MD Director 215-17-7196 1 X M 2 25 1983 May 4. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No 28a-f show Maryland Charles Waldorf notified at once. with the Maryland Director 10g. Citizen of What Country 10f, Zip Code 10e. Street and Number 3562 Pine Cone Circle 23a or 20602 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. must be Armed Forces 1 X Never Married 2 Married 2 X No Yes Divorced Yes. Give Yes Yes 2 X No specify: Specify: Widowed White traumatic event, the Medical Examiner "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) it. Pages 1 and 2 should be filed within 72 hour them to Fleath and Montal Hygiene. Transt: If litem 27 is marked other than "natue or other traumatic own." Completed during most of working life. DO NOT use retired) Complete Building Elementary/Secondary (0-12) College (1-4 or 5+) Services Electrician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John E. Kusztos Stephanie A. Painter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Stephanie A. Kusztos/ Mother 3562 Pine Cone Circle, Waldorf, Maryland, 20602 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 X Cremation 3 20b. Place of Disposition (Name of cemetery, timore, crematory or other place) Removal from State Department or Important: injury or oth **Huntt Crematory** March 1, 2009 Waldorf, Maryland Other Specify Donation 5 22. Name and Address of Facility Signature of Funeral Service Licenses Huntt Funeral Home m01284 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart 20601 Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Oxycodone intoxication Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine nause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f, per ME g890 4/2/09 TT attending physician or use as the burial -XUNPENDED Box 68760. IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ş Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 Yes No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Hospital: Other, Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 After this 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natura Yes 2 X No n 24 hours after death.

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detely filled in by the fu unk 5 Pending Fd 2/21/09 Fd 4:30 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 35 62 Pinecone Circle Waldorf, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide house determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal

the Hospital or Attending Physician: To the

Assistant Medical Examiner 32. Redistrar's Signature ENECUA

and manner stated

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Margarita Korell MD.

31. Date filed (Month, Day, Year)

backer

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 22, 2009

29d. Date signed (Month, Day, Year)

State

Registrar

		For State Registrar		State o	f Marylan	_	artment rtificate			and N		giene Reg. No. 2	009	0.6	847
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/Medic Examin				, give street and nu East New Ma		hd	4b. City,						inty of Death		
Funeral		5. Social Security N		6. Sex	7. Age (In yrs.		If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th	9. Birth	place (State o	r Foreign
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Page tment tant: It jury o		4 □ Donation	5 Other (S	pecify)	Our	Lady o			L .					Marylan	ıd
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Licensee	ller	Z 2 2 2 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1	Name an eller 06 Ma:	Fune Fune In St	s of Facilit eral creet	Home Fa	P. O. ast New	Box Marke	207 t, MD	21631	
		shock, or hea	art failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory a	arrest,		Approximate Interval Bet Onset and I	ween
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To th within To th comp.	Me	29b. Signature and	title of certifie	r		no		License				29d. Date si	gned (Month	n, Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Clara Kent 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wiconico Jalisbury
If Under 1 Year If Under 24 Hrs. Hospice at The Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 223-38-7205 1 □ M 2 🕱 F Months Davs Hours Director 90 03/12/1918 <u>Virginia</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State rai", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1109 S. Schumaker Dr., #307 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21☑No Specify white <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry injury or other traumatic event, the Wedical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lee Franklin Bousman Irene Angle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Feffer/daughter 12641 Whisper Trace Dr., Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/16/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 222 Name and Address of Facility Home, Professional Association Kert 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BRIPHERAL VASCULAR DRSRASR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-tran resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA PHOther (Specify) HOSPICA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the this certificate After ours after death.

lerai Director: A
filled in by the ft within 24 hours a

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

State

HOSPICE

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OASTAT 32. Registrar's Signature DO058410

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State of Maryland / Department of Health and Mental Hygienes 06849 State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Steven Dean Kelton 13, 2009 9:35 <u>February</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Montgomery Casey House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F 58 215-52-5185 March 24, 1950 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Item Modical Examinations in most be modified at 1 Yes 2 No Silver Spring Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20902 United States 10803 Bucknell Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If ¶es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\stackrel{\text{Elementary/Secondary (0-12)}}{10 \ years}$ College (1-4or 5+) Private Electronic Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Bernice Johnson Arthur R. Kelton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele S. Kelton - Wife 10803 Bucknell Drive Silver Spring, MD 20902 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. lington Nat'l Cemt. Feb 27, 2009 Arlington, VA 4(☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. Sign ture of Funeral Service Licensi 4001 Benning Road, NE Washington, DC 20019 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Metastatic Pancreatic Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 Fetal death 3 Ectopic pregnancy Day 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo Hospice Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 X Natural nours after death.

neral Director: A
y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do063748 February 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, MD Jocelyne Kouatchou, M.D. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2009 06850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 32 **Physician** Kaiser James Earl 11:28A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 11819 Messick Road Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day_Year) Nov 27, 1934 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 218-30-0472 74 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If Item 27 is marked other than 1000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 □Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 11819 Messick Road 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Pipefitter** PPG Industries 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl James Kaiser Maida LaNon Wright Kaiser ဂ္ 19a. Informant's Name/Relationship (Type. Print)

Jackileen Kaiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11819 Messick Road Cumberland MD 21502 wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/27/2009 Flintstone MD 4 Donation 5 DQther (Sp@cify) 21. Signature of Funeral Service Licens 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or liver failure. List only one cause of each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a conse lience of): Approximate Interval Between Onset and Death **Physician** to Urs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consecuence offi-To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the Innertal director, page 2 should be detached for use as the burial-transit aftending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

29b. Signature and title of ge

31. Date filed (Month

625 Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

DOU 33280

(CUMBERLAND, MI)

29d. Date signed (Month, Day, Year)

2005

State Registrar 31. Date filed (Month, Day, Year)

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LEENA

32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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KODALI 14090 HG Trueman Rd., Solomons, MD 20678

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2.27.2009

			Mark Parkhurst, MD 3110 Gracefield Road, Si	.iver spring, MD 20904		
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	fo the Host vithin 24 ho fo the Fune completely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Certifying Physician: To the best of my knowledge, death and meaning the physician of the best of my knowledge, death and meaning the physician of the best of my knowledge, death and meaning the physician of the best of my knowledge, death and meaning the physician of the best of my knowledge, death and meaning the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of my knowledge, death and the physician of the best of the physician of the best of my knowledge, death and the physician of the best of the physician o	occurred at the time, date and place, and divestigation, in my opinion, death occurred at 29c. License number	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	С	ocation (Street and Number or Rural Route Number lity or Town, State)	r,
n of V	ling Physk		1 ☐ Yes 2 1 No	28c. Injury at Work?	5 Residence 6 Other (Specify) Describe how injury occurred	
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68760,	ficate be executed physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
	/Medical Examiner	Į.	Due to (or as a consequence of):		2 Years	
Change	Physician [®]	F 10	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Myelofibrosis	er the mode of dying, such as cardiac or res	Interval Betwee Onset and Dea	en ath
Ball	permit. Page Department of Important: If any injury or once.		21. Sign ure of Juneral Service Licensee Licensee 22 Fr. 56	name and Address of Facility rancis J. Collins Funeral On University Blvd. West,	Home Inc. Silver Spring, MD 20901	
altimore,			TEADURAL 2 C. Clemation State	sition (Name of natory or other place) ardens Cemetery	2009 20c. Location - City or Town, State Arlington, VA	
	is 1 and 2 should of Health and Meritem 27 is marker other traumatic		Paul John Liposky / Nephew 394	O Loch Ness Court, Freder	ick, MD 21704	
Maryland	should be and Mental ls marked o	70	John Lipovsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	Anna Or		
1d 21	e filed within al Hygiene. other than vent, tre	Be Co	17. Father's Name (First, Middle, Last)	CPA 18. Mother's Name (Firs	st, Middle, Maiden Surname)	
21215-0036	within 72 ho iene. than "natur the Medical I	Completed	(Specify only highest grade completed) (Give life. I	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry Department of Army	
980	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or items 23a or 28a-f show event, it is invided Exami at must be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ XYes 2 □ No	Was Decedent of Hispanic Origin? (Specify \ If Yes, specify Cuban, Mexican, Puerto Ricar □ Yes 2 ☑ No Specify:	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White	
	ath with \$23a or	ral Di	3160 Gracefield Road #2110	10f. Zip Code 20904	USA	
	the Mary 28a-f sh	Director	Prince George Silver S MD Frederick Frederick		1 ☐ Yes 23	No No
	/land		Usual Residence of Decedent 10a. State · 10b. County 10c. City, Town or Lo		10d. Inside City	Limits
	Funeral Director		5. Social Security Number 578–22–8275 6. Sex 1 □ (In yrs. last birthday) 92 Yrs.		Pate of Birth Month, Day, Year) 9. Birthplace (State or F Country) PA	Foreign
,,,,,	Examir	er	4a. Facility Name (If not institution, give street and number) Renaissance Gardens - Riderwood Village	4b. City, Town, or Location of Death Silver Spring	4c. County of Death Prince George's	
· Lange	Physici /Medio		John Paul Liposky	F	Month Day 12, Year 2009 11:25	
			1 - State RegistraMFND#10a-fiperINF, 2-24-09, FMW, McCo 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. No. 2 0 0 9 0 6 8 Date of Death 3. Time of De	
			4	artment of Health and Men		m 0

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Francis Aron Lee 8:40 p February 15, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 ੌ M 2 🗆 F Months 315-01-8462 88 Yrs April 18, Illinois Director 1920 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show notified at show 1 □ Yes 2 TVNo Director Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 must be n 2730 Jennings Road 20895 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ral", or item Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ∑XYes 2 □ No If Yes, Give Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "natur traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Technician Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked otl Be Frank A. Lee Lena M. Cummings ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Geraldine A. Lee/Wife 2730 Jennings Road, Kensington, MD 20895 Health a other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. tx Burial 2 ☐ Cremation 3 ☐ Removal from State 19, Gate of Heaven Cemetery 4 ☐ Donation 5 Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. f Fyneral Service 21. Signatu 1,20 500 University Blvd. W. Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Gastrointestinal Bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No the a 9 Unknown ed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, sign. Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of ate has I page 2 s 2 □ No 1∐ Yes 2X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 X ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 □ Yes 2 □ No ours after death.

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filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifler 🛮 🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney/stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D67589 February 16, 2009 wo D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Harfold Lawson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registra 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 10, 2009 **Physician** 7:30P. M Beverly Ann Shelton Lewoc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1937 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 👽 F ARKANSAS 436-54-2271 72 Director Usual Residence of Decedent 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at once. 10a. State 10c. City, Town or Location 1 ☐ Yes 2 X No Prince George's Silver Spring Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20904 United States 3144 Gracefield Road, GV320 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. Specify: þ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goddard Space Center Management 1-4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther P. Shelton Nell Stratton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6402 Shannon Road Pine Bluff, Arkansas71603 Jerry Shelton -brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 2/17/2009 Mer Rouge Cemetery Mer Rouge, Louisiana 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses Donald Torgwordt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial Infarction sudden disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and physician at the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 🖸 No Month Year Day 5 Other (specify) Division of Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Progressive Supranuclear Palsy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Ves 2A No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Menner of Death 1 ⚠ Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending ours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D22966 February 13, 2009 30. Name and address of person who completed cause of death whem 23a) (Type, Print)
Thomas H. Burguieres, M.D. LRH, ED 7300 Van Dusen Road Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 18 2009 Registrar

			State Registrar	tate of Mar		epartment of Certificate of	Health and M Death	Re	g. No. 2009	06855
н	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
Mary.	/Medio		GRACE STONE LOYD 4a. Facility Name (If not institution, give street	et and number)		4h City Town	or Location of Death	FEBRUAR	Y 15,2009 4c. County of Death	12:35P ^M
1	Examir	er	352 MARLBORO ROAD			LOTHIAN			ANNE ARUN	
	Funeral		5. Social Security Number 6. Sex		In yrs. last birtho			8. Date of Birth Month, Day MARCH 2		place (State or Foreign
	Director		228 26 4825 □ 1□ M	² / ₃ / ₄ 83	Yr:	s. World's Days	Tiours Will.	MARCH 2	3,1925 VIR	STNIA
	ww		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town o	r Location				10d. Inside City Limits
	Maryla f sho	ō	MARYLAND ANNE ARUNI		LOTHIAN					1 □Yes 2 No
	the l	Director	10e. Street and Number	للتار	LOTITAN	10f. Zip Code		10	g. Citizen of What Cou	ntry?
	3a ol	al D	352 MARLBORO ROAD			20711		1	UNITED STAT	ES
	ems er mu	Funeral		Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of	Hispanic Origin? (Spe		14. Race - Ameri Black, White,	can Indian,
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evanirar must be rodified at	þ	1 Married 2 Married 2 Married	1 □Yes 2 M No fYes, Give Year or Dates:		1 □ Yes 2 █ No		, , , , ,	Specify: WHIT	
5-0	72 ho	Completed	15. Decedent's Educatio (Specify only highest grade co.	on mpleted)	(6	ecedent's Usual Occu	during most of working	1	6b. Kind of Business/Ir	
121	ithin ne. han "	mpl		College (1-4or 5+)	li.	fe. DO NOT use retir	ed)		DUCATION	
2 2	filed w Hygie ther t		17. Father's Name (First, Middle, Last)	⊃ †	ILA	CHER	18. Mother's Name		EDUCATION aiden Surname)	
Maryland	be eve	To Be	WILLIAM H. LOYD				BLANCHE	AMBLER	araeri barriario,	
ary.	d 2 should th and Mer 7 Is marke traumatic	-	19a. Informant's Name/Relationship (Type. i	Print)	19b. M	lailing Address (Stree			City or Town, State, Zi,	o Code)
Ž			DORIS L. KYLE (NIE	ECE)	227	SUNNYSIDE	ROAD WA	RRENTON	.MISSOURI	63383
ore	ges 1 and it of Healt If item 27 or other 1		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Remo	aval from State	20b. Place of Di cemetery,	isposition (Name of crematory or other pla	ace)	ate 2	0c. Location - City or To	own, State
Ĕ	nit. Pag artment ortant: I injury o		4 □ Donation 5 □ Other (Specify)	oval from State	KALAS	CREMATORY	•		EDGEWATER, M	
Baltimore,	permit. Pages : Department of I Important: If ite any injury or of		21. Signature of Funeral Service Licenses	1/2					ALAS FUNERA	
	TD 7 % Q		23a. Part1. Enter the disease, or complication	one that caused th	o doath. Do not		MONS ISLAN		EDGEWATER,	MD. 2103/ Approximate
	Discosio i o o		shock, or heart failure. List only one ca	ause on each line.	1	1	0 0	ulur		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	Due to (or as a c		ue hea	- Ju	00,00.		1 geors
	Examiner		0	(, , , , , ,	U					V
	₽ ∺	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a c	consequence of):					
	xecute and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
68760,	tificate be executed g physician and as the burial-transit	alE		540 10 (0) 40 4 0	onocquenoc on,					
687	rtificate ng phy as the	edical	d							
Box		M/ns	23b. Was decedent pregnant	f yes, outcome of 1 ☐ Live birth 2 I	pregnancy	3 ☐ Ectopic pregnar	acv.		23d. Date of deliv	,
Ö	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	1 Ves 2 No	4 □ Pregnant at tii 9 □ Unknown		5 ☐ Other (specify)			Month	Day Year
о. С.	that ned by deta		Part II. Other significant conditions contribu		not resulting in th	e underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
of Vital Records,	w requires s been sign should be	ed by	Type 2 dia	here	mell	litus		1 ☐ Yes	s 2XNo 3□ Pro	bably 4 ☐ Unknown
မင္မ	law requas been 2 shouk	Completed	Coronary	after	n di	scare		24a. Was an autopsy	24b. Were auto	ppsy findings available ompletion of cause of
B		Som	0		0			perform	ed? death?	
/ita	Physician: this certific al director,	Be (25. Was case referred to medical examiner?	M=1.			26. Place of Death		4	
of	ys dir	은	1 Yes 2 No Hosp 27. Manner of Death 2	1 ☐ Inpatient	2 ER/Outpa				nce 6 Other (Speci	fy)
Ou	ding T. After fune	Certification:	11 Natural 5 Pending 2 □ Accident investigation	(Month, Day, Y	/ear) 28b. Tim	ry Wo	ork? □Yes 2□No	8d. Describe hov	v injury occurred	
Division	I or Attendi after death. Director: A I in by the fu	ifica	2 Disuiside 6 DiCould not be	8e. Place of Injury	- At home, farm,	, street, factory, office		8f. Location (Stre	eet and Number or Run	al Route Number,
Ö	tal or A	Cert	4 I Hornicide	building, etc.	эреспу)			City or Town,	State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifler (Check only only) (Check only) 29b. Signature and title of certifler 29b. Signature and title of certifler 20b. Signature and title of certifler 20b. Signature and title of certifler 20c. Name and address of person who complete 20c. Name and address of person who complete 21b. Date filed (Month, Day, Year) FEB 1 7 2009	n: To the best of on the basis of each manner state	my knowledge, d xamination and/d d.	leath occurred at the or investigation, in my	time, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as te and place, and due t	stated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	~~~	MD	29c. Licer	se number	29	d. Date signed (Month,	Day, Year)
			Monia Cliri		1-010	194	8101	F	EBRUARY 16	,2009
	40		30. Name and address of person who complete the complete that the complete the complete that the compl	eted cause of dear	th (Item 23a) (Ty	pe, Print) on Ce Have	Sunta 112	Annaha	els MD :	21401
	W Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	01130 11000	33	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Registr		FEB 1 7 2009	Genera	1. So	aled				
			,		4 /					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 18, Billings Leonard 2009 February

7. Age (In vrs. last birthday)

70

10c. City, Town or Location

Gaithersburg

4h. City. Town, or Location of Death

if Under 1 Year | If Under 24 Hrs.

Hours

Min.

Gaithersburg

Months Days

10:00 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

4c. County of Death

Montgomery

Montana

1938

8. Date of Birth (Month, Day,

Aug 18,

Physician /Medical **Examiner**

1 - For State Registrar

10a, State

MD

Directo

Be

Examiner

Be

Certification: To

Medical

State

Registrar

31. Date filed (Month.

Brooke

5. Social Security Number

517-42-8767

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

1 □ M 2 □XF

9536 Briar Glenn Way

10b. County

Funeral Director

with the Maryland 28a-f show th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exandrater was beneathed at Pages 1 and 2 should be filed within 72 hours after death Department of Health a Important: If item 27 Is any injury or other tra once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a icate has been si certificate funeral director, After nours after death.

neral Director: Aft
filled in by the fun 24 hours To the Hosp within 24 hou To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Montgomery 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 20886 USA 9536 Briar Glenn Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 💢 No Completed by If Yes, Give Year or Dates: Specify. 3 ☐ Widowed 4 ₹ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technical Writer Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Geraldine Goheen Barnum Josh Billings, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 912 Skalkaho Hwy. Hamilton, MT 59840 R. Morna Leonard/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory: 02/19/09 Odenton, MD 21. Signature of Funeral Service Li-Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years disease or condition resulting in death) Kidney Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underly groups (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2√ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ∐Yes 2 X No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number D45880 February 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Hwang, M.D. 1221 Mercantile Lane Largo, MD 20774

DHMH 17 Rev 1/2001

parked

32. Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 13, 2009 **Physician** 8:55 P™ Neng Funn Lin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montgomery 13 Maxim Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug 20, **Funeral** Months Days Hours Min. Aug 81 China 578-96-0771 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner, just be notified at 1√2 Yes 2 □ No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or USA 20852 13 Maxim Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married o. Baltimore, Maryland 21215-0036 1 □Yes 2 🖔 No If Yes, Give Year or Dates: Specify Specify: Asian 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It is Medic one. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Taiwan Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) (unk) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>315 Argosy Drive Gaithersburg, MD 20878</u> Chow Lee Lin/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State W. Arundel Crematory | 02/19/09 Odenton, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Rectal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ∐Yes 2 1 No 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending neral Director: A investigation 1 ☐Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar

Medical

29a, Certifie

(Check only one)

29b. Signature and title of certified

Nicholas J. Farrell, M.D. 9707 Medical Center Drive Rockville, MD 20850 31. Date filed (Month, Day, EB 19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature parked

1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D67258

29c. License number

29d. Date signed (Month, Day, Year)

February 17, 2009

State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \be Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 7:00 ам February 18, 2009 Jean E. Linton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Nursing&Rehabilitation Ellicott City Howard If Under 1 Year If Under 24 Hrs Hours Min. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Days Months 1 ☐ M 2 🕱 F 59 Director 212-09-4630 12/17/1949 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Md. Ellicott City Director Howard 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10088 Maplewood Drive 21042 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural" ~ "norter other traumatic event *** 1 ₩ Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George H. Linton Marjorie E. Cavey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10088 Maplewood Drive Ellicott City, Md. 21042 Myrna Costa/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 Removal from State 2/23/2009 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cem. Ellicott City, Md. 22. Name and Address of FacilityHarry H.Witzke's Family F.H.Inc. 21. Signature of Funeral Service License D MOO845 4112 Old Columbia Pike Ellicott City,Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONI /Medical s a consequence of): Due to (or Examiner Sequentially list conditions, Dies to for as a nonsequence of Examiner than, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed bunial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 TARRATION 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

State Registrar

29a. Certifier

29b. Signature and title of certifier

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

NRolling Rd Ste 205 Cetonsville 21228 516 OPOIFO REZNAME E MO 31. Date filed (Month, Day, Year)

| Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

FEB 19 2009

32. Registrar's Signature Ceneura barks

Hend

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:15PM M CHARLES V. LAVIN FEBRUARY 10 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 9672 LEEDS LANDING CIRCLE EASTON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 066-20-8828 81 Director APR 20, 1927 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 📉 No Director MD TALBOT EASTON 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Number 9672 LEEDS LANDING CIRCLE 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examine. once. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICER 12 U.S. NAVY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ CHARLES M. LAVIN LEILA J. HUMMELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA LAVIN/WIFE 9672 LEEDS LANDING CIRCLE, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON NATIONAL 4/8/2009 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph USTROUSK 200 S. HARRISON ST EASTON, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic leass /Medical Due to (or as a consequence of): Examiner Hypertuanoc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation in 24 hours are; the Funeral Director: Af maletely filled in by the fu 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

SYED I. ALI M.D. 505A DUTCHMANS LANE EASTON, MD 21601

FEB 1 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TLS

20+VA

MD

29c. License number

00046020

29d. Date signed (Month, Day, Year)

			1_ State	epartment of Health and Certificate of Death		ene J. No. 2 () () 9	06860
	Physici	an	Decedent's Name (First, Middle, Last)	I U	2. Date of Death	Day Year	3. Time of Death 23:33 AM
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Dea		4c. County of Death	23.23 Tm
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	(ay) If Under 1 Year If Under 24 Hr		9. Birthp Coun 1925 C	place (State or Foreign try) hina
	Maryland I-f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD Montgomery Be	or Location ethesda			10d. Inside City Limits
:	n with the 23a or 28a st be notifi	al Director	10e. Street and Number 4521 East-West Highway, #410	10f. Zip-Code 20814	10g.	g. Citizen of What Coun	itry?
98	rs after dear ", or items aminer mu	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Warried 12. Was Decedent Ever in U.S. Armed Forces? 1 Pes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) □ Yes 2 XNo Specify: 	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:	
215-0036	should be jiled within 72 hours after death with the Maryland and Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 24a or 28a-f show matic event, the Medical Examiner must be notified at	Completed I	15. Decedent's Education (Specify only highest grade completed) [Secondary (9.12) College (1.4 or 5.1)	ecedent's Usual Occupation Give kind of work done during most of wife. DO NOT use retired) Professor	orking 16	Sb. Kind of Business/In	
and 2121	eve eve	Be	4 yrs 17. Father's Name (First, Middle, Last) Hong Zhang Liu	18. Mother's N	lame (First, Middle, Ma nu Jiao Z	,	ion
2	d 2 s th ar 7 is trau	D		Mailing Address (Street and Number or I 21 East-West Hi	Rural Route Number, C	Cify or Town, State, Zip	2081/
more	Page nent o int: If iry or		20a. Method of Disposition 1 ☐ Burial 2 [**XCremation 3 ☐ Removal from state cemetery,	oisposition (Name of crematory or other place) Crematory 2/	Date 200 17/09	nc. Location - City or To Hanover,	wn, State
Balt	permit. Departn Importa any inju			22. Name and Address of Facility S 246 N. Washingt	on St, Ro	ckville,	
	hysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	el	do or respiratory arrest	-	Interval Between Onset and Death
	xaminer	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of)	· .			
760,	are be executed hysician and the burial-transit	edical Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of)	:			
	the the	Ψ.	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delive	ery
P.O. B.	ires that the death signed by the atte d be detached for	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown	5 Other (specify)	00- 5-44	Month	Day Year
Records,	ine law requires that the death certific te has been signed by the attending p page 2 should be detached for use as	eted by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Fart i.	1 ☐ Yes	2 No 3 Prob	1/
		Be Completed	25. Was case referred to medical	26. Place of D∈	 autopsy performed 	prior to co	mpletion of cause of
n of V	ig Physicia ter this cert ineral direct	၉	examiner? 1	ne of 28c. Injury at	Home 5 TResidence)
Division of	ure nospinal or Attending Fritysicians. within Ea hours after death. To the Teneral Director After this certifica completely filled in by the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	M	28f. Location (Stree Cify or Town, St	et and Number or Rura State)	al Route Number,
	n 24 hours n 24 hours ne Funeral	Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knowledge, dependence on the basis of examination and/of and manner stated.				
	withi com	Ž	29b. Signature and title of pertitier	29c. License number RES-000		Date signed (Month, Ebruay 14	
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Ty Matthew Crowles 31. Date filed (Month, Day, Year) 32. Registrar's Signature	600	North Wolfe	St, Baltimor	e, MD, 21287
	Registr		31. Date filed (Month, Day, Year) FFR 1 7 2009 32. Registrar's Signature	arked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Langrall Betty Jane Feb. 2009 0410 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Wicomica Salisbury er 1 Year | If Under 24 His. Selisbur, Rehabilitation Aursing Ctr 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birth 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Months Days Hours Min. Maryland 1 □ M 2 🛛 F 10/27/1925 83 220-12-1305 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State M Yes 2 □ No Ocean City Maryland Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21842 USA 13801-G Sand Dune Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. Specify: white 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) education teacher 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alton P. Brittingham Alice Dennis 19a. Informant's Name/Relationship (Type. Print)
Dean Langrall/son 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Cade) 13801G Sand Dune Rd., Ocean City, MD 21842 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 2/17/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause eq each line. Immediate Cause (Final disease or condition resulting in death) ex 200 Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 □Yes 2 3 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 ☐ Yes 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

/Medical **Examiner** Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Division of Vital Records, P.O. Box 68760, peen s has certificate this After t i or Attending Faffer death. Director: filled in by thin 24 hours a To the Hospital
within 24 hours a
To the Funeral C
completely filled

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Modical Examiner must be notified at

permit. Pages Department of Important: If it any injury or o once.

Physician

/Medical

Director

Funeral

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Completed

Be

Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

State Registrar 29b. Signature and title of certifier

Jilliam H.

31. Date filed (Month, Day, Year) FEB 17 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robins, M.D

32. Registrar's Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month. Dav. Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 12 2009 FEBRUARY 10:35 A M **Physician** Μ. LOCKWOOD MAURICE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL **CHEVERLY** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, SEPT • 9 6. Sex 1 AM 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months WASHINGTON, DC SEPT. 1963 45 578-96-7075 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at annew. 10a. State 10b. County 1 XYes 2 No Director CAPITOL HEIGHTS PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 USA 1207 ADDISON ROAD # 224 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No
if Yes, Give
Year or Dates: 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 📉 No Specify: Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE LABORER 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN BURROUGHS MAURICE LOCKWOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3210 ACCOLADE DRIVE CLINTON, MARYLAND 20735 MAURICE LOCKWOOD/FATHER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 2/19/2009 SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Juneral Service Dicensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) METASTATIC COLON CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown ۵ 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I of Vital Records. ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has perform page 1 □Yes 2 X No X∏No 1 Yes certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 ANatural 28b. Time of 28d. Describe how injury occurred Division Injury Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: Af
d in by the fur 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058213 completed cause of death (Item 23a) (Type, Print)

.D. 7525 GREENWAY CENTER DRIVE SUITE 116 GREENBELT, MARYLAND 30. Name and address of person who 20770 FARHAD JAMALI M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 19 2009 Registrar

09-01394 John Larry Lloyd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 06863

		- For State	Certifica	te of l	Death				Reg. N	D.		0000
Physicia		egistrar I. Decedent's Name (First, Middle,Last)						Date of De		Voor		e of Death
Medical Examin		John Larry Lloy	đ				1	Month February	Day 7 17, 2	Year 2009	01	15 hrs
		4a. Facility Name (if not institution, give stre	The state of the s	4b	. City, Town, or I	Location of	Death			4c. County of	Death	
		W/B Rt. 50 at Anacostia Rive			Cheverly					Prince Ge	orge's	
_		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe	day)	If Under 1 Year	If Under	24Hrs.	3. Date of I	Birth (M	M/DD/YYYY)	9. Birthplace	(State or
Funeral Director		579-15-4981 _{1x}	0 ' '		Months Days	Hours	Min.	Apr	11	1987	Foreign Country)	DC
Silecto.		· · · · · · · · · · · · · · · · · · ·	2 F 21	Yrs.								- BC
,	-	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town o	r Locatio	n						10d. I	nside City Limits
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Maryland 28a-f show any d at once.	5		eorges Suilan	.a					10- 0	itizen of Wha	t Country?	
Aaryl 28a-		10e. Street and Number 3334 Curtis DR #	202		10f. Zip Code						t Country?	
with the Maryland us 23a or 28a-f sho he notified at once	훕	JJJ4 Cultis DK #	303		20746				0.	S.A.		
with with	ᇛ	11. Marital Status	. Was Decedent Ever in U.S.	13. Was	Decedent of His	panic Origi	n? (Spec	ify Yes or	No-	14. Race - White,	American Inc	dian, Black,
iten ust b	Funeral	1 XNever Married 2 Married	Armed Forces? Yes 2 X No	If Ye	s, specify Cuban	, Mexican,	ruerto Ri	can, etc.)		WING,	610.	
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5-0036 lled within 7 Hygiene. t other than the Medica	팃	17. Father's Name (First, Middle, Last)		_		18.Mother's	Name (F	irst, Middle	e, Maid	en Surname)		
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21215-0036 ould be filed within 72 d Menal Hygiene. s marked other than "ire event, the Medical ire event, the Medical	일	19a, Informant's Name/Relationship (Type	Print) 19b	Mailing	Address (Stree	t and Num	ber or Rui	al Route N	lumber,	City or Town	, State, Zip C	ode)
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Pag Cant:		4 Donation 5 Other Specify:			ame and Address	of Facility	Mel.	augh	115	Fline	rall	Omo
Baltimore, permit, Pages I and Department of Heal Important: If iten		21. Sign while of Funeral Service License		22. N	ame and Address	Jr 2	Ve	SE W	ash	ingto	n DC	20020
and the second second		23a. Part I. Enter the disease, or comprise	m									proximate Interval
Physician	d	23a. Part I. Enter the disease, or complication failure. List only one cause on each		t enter tri	e mode of dying,	Such as Co	aluiac or i	espiratory	arrest,	311001, 01 1100	Be	ween Onset and
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hammer	- 1	or condition resulting in death)	to (or as a consequence of):									1
	u	Sequentially list conditions, b.		_			_		_			
	<u>e</u>	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a consequence of):					8				
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P.O. Box 68760, es that the death certificate be executed gared by the attending physician and be detached for use as the burial - transit	/Medical	UNPENDED	MENDED	_								
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876 ifficate		23b. Was decedent pregnant in the	1 Live birth 2	Fet	al death 3	Ectopic	pregnan	су	- 1	Month	Day	Year
x 6 h cert tendii	is.	past 12 months?	Pregnant at time of death 5		ner (Specify)				1			1
Box 68 e death certif the attending ed for use as	Physician		9 Unknown									
O. at the		Part II. Other significant conditions co	ntributing to death but not resulting	in the u	nderlying cause	given in Pa	irt I.					use of death?
es the	d by							1	Yes :	2 No 3	Probably	4 🗸 Unknown
Division of Vital Records, P.O. and or Attending Physician: The law requires that the Taber death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed							24a. W	as an Jopsy			findings available etion of cause of
COF law law has b	ldu			_		-		_ pe	erforme	d? d	eath?	2 No
The The	ပ္ပ			***	00.0	6 P) Alm	(Cheek e	-	es 2_	No 1	✓ Yes	2 110
inan:	Be	25. Was case referred to medical examiner?	pital: 1 Innationt 2 ER/O			e of Death Other		Home 5		sidence 6	Othor: Coo	
this sign	2	1 🗸 Yes 2 No	I inpatient 2 Ervo	utpatient						injury occurr		
Of Ing P After Unners		27. Manner of Death	(Month Day Year)	Time of I hrs		ury at Work		Subject o	river	of vehicle	in vehicul	ar accident
condition the f	aţ;	1 Natural 5 Pending 2 ✓ Accident Investigation				Yes 2 ✓						
/js r At red in by	ij	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	arm, stree	et, factory, office	building, et	- 1	or Tow	n. State	e)		oute Number, City
illed in	Certification:	4 Homicide determined	(Specify) Major Road / Hi	ighway			<u> </u> V	V/B Rt. 50	at Ar	acostia Riv	er Bridge, S	uitland, Md.
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	al C	29a. Certifier 1 Certifying Physician	To the best of my knowledge, de	ath occur	red at the time, o	date and pla	ace, and o	due to the	cause(s) and manner	as stated.	
thin 2	Medical	one) 2 Medical Examiner: O	n the basis of examination and/or i	nvestigat	tion, in my opinio	n, death oc	curred at	the time, c	late and	d place, and d	ue to the cau	se(s)
To To	Me	29b. Signature and title of certifier	a mainio otatoa		29c. Licen	se number			2	9d. Date sign	ed (Month, D	ay, Year)
		TO 111	1.		O.C	.M.E.	00	ME	F	ebruary 1	7, 2009	
		/ Levdon M. /	polated chairs of death (Hom 22a)	w				_				
10 0		30. Name and address of person who cor Theodore M. King, Jr., MD.	Assistant Medical Exam	iner	111 Penn S	treet, Ba	Itimore	, MD 21	201			
1		5 7 5 1 at a 5 2 2 3 1					_					
S	tate		32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MARIE P. LOSS 24, 2009 6:50 P February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Jarrettsville 4155 Tangier Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□√F Months Days Hours Min Yrs 91 7/30/1917 Illinois Director 325-10-6874 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Harford Jarrettsville 1 ☐ Yes 2 ▼No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 USA 4155 Tangier Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ≥ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evance. Angela Pietruski Ludwig Wijas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9805 Wilden Lane, Potomac, MD 20854 Roderick J. Loss/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/28/2009 Pylesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Vo 100 17314 Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Muccardia One 12au /Medical **Examiner** Pars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): リルイルと トレンン Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has certificate l 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation rector: / by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) 29c. License number 29b. Signature and title of certifier

Registrar

State

30. Name and address of person w

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

V WD

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 06865 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEB. 14, 2009 ROBERT McCLENDON 0840 LEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 4,1948 | Tennessee Suburban Hospital 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 **X**M 2 □ F Yrs. 60 411-86-1355 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at tyEYes 2 □ No Director New Hanover Wilmington NC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28405 415 Clay Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★o Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Cook Burger King llth permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James McClendon Hattie M. Walker ပ 19a. Informant's Name/Relationship (Type. Print) (Brother), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. McClendon, Jr 415 Clay Street, Wilmington, NC 28405 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burjal 2 X Cremation 3 ☐ Removal from State Ardent Crematory 2/18/09 4 Donation 5 DOther (Specify) Hanover, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. fo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duc to (or as a consequence of) physician and the burial-transit 1 Pndon 1000, + Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □ Yes 1 ☐Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? To the Hospital or Attending P. within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D0062435 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Dr, Rockville, MD 20850 Sayed Elsayyad, M.D.31. Date filed (Month, Day, Year) egistrar's Signature FEB 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes of October

			1 - For State Registrar 1. Decedent's Name (First, Middle, La	Otato of Mary		ertificate of		R	eg. No. ZUUS	06866
	Physici /Medi		Leonard Joseph Mak	·				2. Date of Deat Month February	15, 2009 Year	3. Time of Death 10:30 a M
	Examir		4a. Facility Name (If not institution, gi Holy Cross Hospital	ve street and number)		4b. City, Town, o	or Location of Deal		4c. County of Death	
ı	Funeral Director		219-64-0884	Sex M 2□ F 55	yrs. last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			place (State or Foreign ntry) asylvania
	Part show	Director		George's	City, Town or	Beltsvil	lle			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
1	3a or 2		10e. Street and Number 4505 Samar Street			10f. Zip Code	0705	11	Og. Citizen of What Coul USA	ntry?
036	portion: Tages I and a should be need within 12 fours are bean with the maryland bean apparent of the falls and model. Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanier cutston influed and once.	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:	n U.S. 1	B. Was Decedent of H If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
:1215-UU36 :::::::::::::::::::::::::::::::::::	within 72 no iene. than "natur	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Gi life	eedent's Usual Occup ye kind of work done DO NOT use retire	during most of word)	rking	16b. Kind of Business/In	,
and 2	al Hygi	Be C	17. Father's Name (First, Middle, Last)		Jubie A red		ne (First, Middle, N	Diesel Mecha Maiden Surname)	nic
y a	d Ment marked matic e	To I	Leonard Makowski	(T	1			rene Raley		
Man y	alth an 27 is r er traur		19a. Informant's Name/Relationship Janet R. Makowski/Wi		19b. Ma				City or Town, State, Zip e, MD 20705	(Code)
Salumore,	ment of He ant; If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Themoval from State D	b. Place of Dis cemetery, cr arklawn	position (Name of ematory or other place Memorial Par	reb k 200	. 18,	Pockville, Ma	·
Dall	Depart Import any inj		21. Sign, ure of Funeral Service Lice	Lole		22. Name and Addre			nc. pring, MD 209	01
E	hysician /Medical xaminer	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events	a. Respiratory Due to (or as a cons b. C Difficile Due to (or as a cons c. Spinal Lymp)	ilumo sequence of): Colitis sequence of): homa	nter the mode of dyir	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between Onset and Death
orou,	physician and the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a cons		sure Ulcer				
or Attending Physician: The law requires that the death certificate be executed	y the attending phiched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcome of preduction 1 Live birth 2 F4 Pregnant at time 9 Unknown	etal death 3	☐ Ectopic pregnanc ☐ Other (specify) _	у		23d. Date of delive Month	ery Day Year
equires that	s been signed by the should be detached	þ	Part II. Other significant conditions of	contributing to death but not r	resulting in the	underlying cause giv	en in Part I.		acco use contribute to the	
n: The law re	certificate has berector, page 2 sho	Completed	OF Management and the first	7				24a. Was an autopsy perform 1 □Yes 2	prior to cor ed? death?	psy findings available npletion of cause of 2 □No
ysicla	is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2√√√√√√√√ No	Hospital: 1 X Inpatient 2	☐ ER/Outpati	ent 3 DOA Othe	or.	th (Check only one,) ice 6 □Other (Specifi	<i>a</i> 1
ending Ph	eath. or: After this certifics he funeral director, p	ation: 1	27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year,		of 28c. Injur Work		28d. Describe how		7
ital or Att	n 24 hours after death. e Funeral Director: Af eletely filled in by the fur	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spe	ecify)			City or Town,	·	
he Hospital	within 24 hou To the Fune completely fil	edical	29a. Certifier (Check only one) 1 ☑ Certifying Ph	nysician: To the best of my kininer: On the basis of exam and manner stated.	knowledge, dea ination and/or	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as si te and place, and due to	ated. the cause(s)
	With Span	Σ	29b. Signature and title of certifier aniedobe	Some		D <i>O</i>	066	62 29	d. Date signed (Month, L	
			30. Name and address of person who Edith Aniedobe, MD	completed cause of death (III			ring, MD 20	910	•	
	Stat Registra	_	31. Date filed (Month, Day, Year)	32 Registrar's Sig						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06867 State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death

			For State Of IVIC		rtificate of D			i. No.	00001
	Discosini		Decedent's Name (First, Middle, Last)				Date of Death Month		3. Time of Death
	Physici /Medio		Judith Ann Mie	lke			February	y 12,2009	22:06P M
Was.	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or l			4c. County of Death	-
			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Ag	c e (In yrs. last birthday)	Annap If Under 1 Year	OLIS If Under 24 Hrs.	8 Date of Birth	Anne Arund	
	Funeral Director		460 00 0000 III 1 2 1 7 1	66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)	(ear) County 1942 Penns	lace (State or Foreign stry)
	pui *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				0d. Inside City Limits
	// Aarylan f show	ō	Maryland Anne Arundel	Too. Oity, Town of Ed	Arnold			l'	1 ☐ Yes 2 🏋 No
	the N	rect	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Coun	try?
	h with	Funeral Director	1228 Timber Turn		2101	2	J	Jnited Stat	es
	r deat	nner	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe , Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, e	
36	filed within 72 hours after death with the Maryland Hygene. sther than "natural", or items 23a or 28a-f show ent, the Medical Examinat must be notified at	by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give X 3 Widowed 4 Divorced Year or Dates:	No	1 ⊡Yes 21∏ No	Specify:			hite
21215-0036	2 hour	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupa	tion	16	bb. Kind of Business/Inc	
215	thin 7. ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5	(Give life.	kind of work done du DO NOT use retired)	aring most of workin	ng		
	led wi lygier her th		5+		Educator	18. Mother's Name	(First Middle Ma	Educatio	n
Maryland	i be fil intal H ed ot	Be	17. Father's Name (First, Middle, Last) Alfred Lilly				e Serfass	,	
Z.	should be fand Mental Be marked of umatic eve	မ	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street a			City or Town, State, Zip	Code)
	1 and 2: Health a tem 27 is other trau		Lynayn Mielke / Daughter					and 21012	
J. C	of He of He item		20a. Method of Disposition		osition (Name of matory or other place			c. Location - City or To	
Ĕ	Pag ment tant: I		1 Denial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	_	Mem. Park			nnapolis, 1	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Evantiner must be notified a once.		21. Signature of Funeral Service Licensee	of Facility John f Glouces	M. Tayl	or Funeral Annapolis,	Home, Inc.		
			23a. Part 1 Enter the disease, or complications that caused shock, wheart failure. List only one cause on each li	the death. Do not ent					Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	cardial In	farction				Onset and Death
	/Medical Examiner		resulting in death)	a consequence of):					
	Examiner	-	Sequentially list conditions, if any leading to immediate	a consequence of):					
	uted d ansit	Examiner	Cause (Disease or injury						
oʻ	e exec an an rrial-tr		that initiated events resulting in death) Last C. Due to (or as	a consequence of):	,				
68760,	rificate be executed by physician and as the burial-transit	Medical	d						
9 ×	certific ding p		IF FEMALE: 23c. If yes, outcome	of pregnancy					
Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/I		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	Day Year
P.0.	at the de by the stached	hysi	9 Unknown						
Š,	w requires that s been signed I should be dete	by F	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.		cco use contribute to th	
Records,	requir	ted	Diarrhea x 1 week				1 ∐ Yes	2 No 3 Prob	ably 4X Unknown
3ec	: The law cate has t	Completed					24a. Was an autopsy performe	prior to cor	osy findings available npletion of cause of
Vital	ician: Th certificate ector, pag		25. Was case referred to medical			00 Pl (D	1 ☐ Yes 2 ☐	XNo 1 □Yes	2 No
Š	nysician: nis certific director,	To Be	examiner?	ent 2 🖫 ER/Outpatier	Other	26. Place of Death		ce 6 ☐ Other (Specifi	<i>A</i>
	ding Ph h. After th funeral	T:U	27. Manner of Death 28a. Date of Inju	ry 28b. Time o		at 2	8d. Describe how		
siol	Attending or death. ector: After by the funer	catic	2 Accident investigation		M 1 □ Yı	es 2□No			
Division	al or At s after d al Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injuilding, etc	ury - At home, farm, str c. <i>(Specify)</i>	eet, factory, office	2	18f. Location (Stree City or Town, S	et and Number or Rura. State)	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	f examination and/or in	th occurred at the time extigation, in my op	e, date and place, a inion, death occurre	and due to the cau ed at the time, date	ise(s) and manner as s e and place, and due to	tated. the cause(s)
	To the comp	Me	29b. Signature and title of certifier	100	29c. License	number	29d	l. Date signed (Month, i	Day, Year)
			Joseph John	7/14	D163	376	F	ebruary 13,	2009
	DCH		30. Name and address of person who completed cause of d Joseph D. Moser, MD 200	eath (Item 23a) (Type, 1 Medical I	•	nnapolis,	Marylan	nd 21401	

Registrar

31. Date filed (Month, Day, Year) FEB 1 7 2009

32. Redistrar's Signature

			1- State Registrar	nd, 1988	3',03'i 3',59allb rtificate of Death	and Mental Hyg 1 Re	iene 009	06868
	Dharisi		Decedent's Name (First, Middle, Last)	11	16	2. Date of Death	n Dav Year	3. Time of Death
	Physicia /Medic	al	Holly Frances	M	210-	Februar	1 23,2009 4c. County of Deat	0920AM
	Examin	er	4a. Facility Name (If ng institution, give street and number) Washington County Hospital		4b. City, Town, or Location		Wash i	
	Funeral		Social Security Number 6. Sex 7. Age (In yr.)	s. last birthday)		er 24 Hrs. 8. Date of Birth		hplace (State or Foreign untry)
L	Director		219 04 7747	Yrs.	monnia Days	Nov.27,	1955 1	ripoli
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. 0	City, Town or Lo	ocation			10d. Inside City Limits
	a-f sh	ctor	Maryland Washington	Hag	gerstown			1 XYes 2 No
	ith the	Dire	10e. Street and Number		10f. Zip Code		0g. Citizen of What Co	
	eath v	Funeral Director	199 Berkson Ave. 11. Marital Status 12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hispanic Clif Yes, specify Cuban, Mexico		USA 14. Race - Ame	rican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Eventual to notified at	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexica 1 ☐ Yes 2 No Specify		Black, White	e, etc. hi†e
21215-0036	2 hour	ted t	15. Decedent's Education	16a. Dece	dent's Usual Occupation kind of work done during mo DO NOT use retired)	ant of working	16b. Kind of Business/	Industry
218	within 7; iene. than "n he Wedi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired) Teacher	ost of working	Educa	tion
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lan	ld be f lental ked o	To Be	William Charles Lindblad			Marv_Jane_M	oore	
ary	2 should be and Mental Is marked a aumatic ev	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Num			Zip Code)
Θ,	and and lealth	l g	Carly Hose - Daughter		Barnhart Rd.		g, Marylan	
nor	Pages nent of hant of hant. If ite		11 Burial 2 V Cremation 3 I Removal from State		osition (Name of matory or other place)		•	
Baltimore, Maryland	permit. Page Department Important: Il any Injury o		21 Signar Son Funeral Services Licensee	()%	Shirement Adulas earlad	lityHome, P.A.		
<u>B</u>	6 2 2 3 3	(Dette CSV		25 S. Conococh			
		7	23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ath. Do not en	ter the mode of dying, such a	as cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) Due to for as a con-	uence of):	Disein	injuny	- 100 - 100 5	1/13/09
	Examiner		SEN	- in	Hickell	Maria	ind	1/13/09
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events c.	equence of):				~
,	execut in and ial-tran	Examiner	that initiated events c	equence of):		BUILD AND ROVED BY	WEST Y, FUS	
68760,	ificate be executed g physician and ss the burial-transit	edical	d		To	EMIFICATION ASSERVED BY		
	# 6 SE		IF FEMALE: 23c. If yes, outcome of preg. 23b. Was decedent pregnant	gnancy			23d. Date of del	livery
Box	that the death cert led by the attendin detached for use a	Physician/M	in the past 12 months? 1 □ Live birth 2 □ Ft 1 □ Yes 2 □ No 9 □ Linknown		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.0	hat the d by the	Phy	Part II. Other significant conditions contributing to death but not r	esulting in the u	underlying cause given in Par	t I. 23e. Did tob	pacco use contribute to	the cause of death?
of Vital Records,	The law requires that the de ate has been signed by the bage 2 should be detached	ed by	Tatti. Silor significant contains commenting to death out the		,,,,,,			robably 4 Unknown
ecc	2 2 2	Completed				24a. Was ar autops	y prior to	utopsy findings available completion of cause of
alF						perform 1 □ Yes 2	2 Mo 1 □ Yes	3
Zit.	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1. The second of the seco	☐ ER/Outpatie	Othor	ce of Death (Check only one Nursing Home 5 Reside	•	ecify)
	ng Phy ter thi neral (on: To	27. Manner of Death 1	28b. Time o	of 28c Injury at		ow injury occurred	1 // -
siol	Attending ir death. ector: After by the fune	catio	2 Accident investigation 1/13/09	113:52			reet and Number or Ru	ted liaugus
Division	after of Direct of in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Pl ce of In fry - Al brilding, etc. (Spe	ecify) Hom	e	City or Town	^{1, State)} 199 Be1	rkson Avenue
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my had cone and manner stated.			and place, and due to the c	ause(s) and manner a	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	1	29c. License numbe	r 2	9d. Date signed (Mont	h, Day, Kear)
			X///10 ×11	44.	0005	10337	2/23	3/09
04	H-1	- 2	30. Name and agrees of person who completed cause of death (I	tem 23a) (Type,	, Print)	+ Mint	# 1	TOL .
0	Sta	ate.	31. Date filed (Month, Day, Year) 32. Pegistrar's Sig	gnature	011-951	WITTE	many-	7
	Regist		FEB 2 4 2009	A. A	Park.			

			State of Maryland / Dep		Mental Hygi	ene
			Registrar	ertificate of Death		. №2009 U5869
ı	Physicia /Medio		1. Decedent's Name (First, Middle, Last) Joseph C. Ma		2. Date of Death Month	Day Year 8:37 P M
-	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dear	h	c. County of Death
<u> </u>			Doctor's Hospital	Lanham		Prince George's
Н	Funeral Director		5. Social Security Number 6. Sex 1. 7. Age (In yrs. last birthday 79 ors. 1. 3. Sex 1. 3. Age (In yrs. last birthday 79 ors. 1. 3. Sex 1. 3. Age (In yrs. last birthday 79 ors. 1. 3. Sex 1. 3. Age (In yrs. last birthday 79 ors. 1. 3. Age (In) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	(Month, Day,	9. Birthplace (State or Foreign Country) 1929 China
	P.		Usual Residence of Decedent	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	arylar show	ř	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Mi	ectc	MD Prince George's Bowie	101 7 O-1	140	1 XYes 2 No
	a or	Funeral Director	10e. Street and Number 12303 Melody Turn	10f. Zip Code 20715	109	g. Citizen of What Country?
	eath	era			Specify Yes or No-	USA 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Modeal Extra the Intelligial angree.		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2€ No Specify:	to Rican, etc.)	Black, White, etc. Specify: Asian
Ö	hours tural"	q pe	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	adonto Housi Ossunation	1 4/	
15	n 72 l	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking	6b. Kind of Business/Industry
212	withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)	mational Broadcas	ster	Radio
D	il Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	
Baltimore, Maryland 21215-0036	uld be Menta Irked Itic ev	To E	John Ma		ai Lian	
ar)	shol and I s ma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or R	ural Route Number, (City or Town, State, Zip Code)
≥,	and; ealth n 27 ner tr			3 Melody Turn	Bowie, M	
ore	t of H If Iter or oth		20a. Method of Disposition 1 ☐ Burial 2分 Cremation 3 ☐ Removal from State	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State
Ē	tmen tant; tant;		4 □ Donation 5 □ Other (Specify) Bayview (7/2009	Baltimore, MD
3aj	permit Depar Impor any In		21. Signature of Funeral Service Licensee		Beall Fune	
	40 2 0 0	-	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	6512 NW Crain Hwy		
	Physician /Medical Examiner	ier	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):			Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burlal-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Discours of Aury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): d.			
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S, P.	res that signed to be deta		Part II. Other significant conditions contributing to death but not resulting in the transfer of the significant conditions.			cco use contribute to the cause of death?
Orc	w requires t s been signo should be	sted	CHRONIC MY ELOCIONOS LIDICEM	uA	1 L Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	ding Physician; The law h, Affer this certificate has b funeral director, page 2 s	Completed by	TYPE 2 DIABLETES HELLING		24a. Was an autopsy performe 1 □ Yes 2 I	
Ë	siciar certif rectol	Be	25. Was case referred to medical examiner? Hospital:	Other:	ath (Check only one)	
οţ	Phys r this ral di	.T	1 ☐ Yes 2 ☐ Hospital 1 ☐ Impatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	TIL 3 DOA 4 Nursing P	lome 5 ☐ Residen	ce 6 Other (Specify)
on	th, th, the the	ij	1 ☑ Natural 5 □ Pending (Month, Ďay, Year) Injury 2 □ Accident investigation	of 28c. Injury at Work? M 1 □ Yes 2 □ No	254. 2550.150 11011	many occanion
Divisi	al or Attending Physician; s after death, I Director: After this certifica d in by the funeral director, i	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal can be compared to the best of my knowledge, deal can b	th occurred at the time, date and plac nvestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month, Day, Year)
	. 1	1	Hillas	DS5559	F	EB120189 12,2009
	Starl		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)		
سزر	March		31. Date filed (Month, Day, Year) 32. Registrar's Signature	SIET SE STORE	, yreary	वरावर तम, रा
	Sta Registr		FEB 1 8 2009			

(§) Ø

31. Date filed (Month, Day Year) 2009 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD

Signature & Sparker

111 Penn Street, Baltimore, MD 21201

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1428PM Mason 2009 Februry 08 Samue 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY Rockville Adventist Hospital

6. Sex 7. Age (In yrs. läst birthday) Shady Grove
5. Social Security Number 9. Birthplace (State or Foreign Country)
Wash. DC 8. Date of Birth (Month, Day, Year) Jan . 12 , 1933 If Under 1 Year | If Under 24 Hrs. 1**∑** M 2□ F Months Days Hours Min. 76 216-30-4572 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No Germantown MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 12912 Churchill Rodge Cir, Unit 20874 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 28 Married 1 □Yes 21 No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chauffeur Private Family 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Amanda Windere William A. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12912 Churchill Ridge Cir, Germantowr 19a. Informant's Name/Relationship (Type. Print) Germantown, MD Barbara Mason (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St Ardent Crematory 2/19/09 Hanover, MD 4 ☐ Donatipn 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature f Funeral Service Li ensee Washington St, Rockville, MD 20850 246 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) minutes Pulmonary Due to (or as a consequent of): Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1∐Yes 2 🖾 No 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed burial-transi ending physician and use as the burial-trar Box 68760. for L this certificate has been signed by the al director, page 2 should be detached O Δ. of Vital Records, **Director:** After this certific I in by the funeral director, of or Attending I safter death. Division filled in by

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

show

ir than "natural", or items 23a or 28a-f show

within 72 hours after

d 2 should be filed within 7 in and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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25. Was case referred to medical examiner?

3 Suicide

29a, Certifier

Medical

State

Registrar

4 Homicide

(Check only one)

5 ☐ Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Center Dr.

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and

2009

29d. Date signed (Month, Day, Year) 08,2009 February

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1/ 31. Date filed (Month, Day, Year) McNeil MD

DHMH 17 Rev 1/2001

To the Hospital or within 24 hours at To the Funeral D

09-01311 David Morgan, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06872

		1- For State Registrar		Ce	rtificate of	Death			1	Reg. No.		
Physicia	an/	1. Decedent's Name (First, Middle							Date of De Month	Day Year	3. Time of Death	
edical Exami	ner			ION MORG				(5	February	13, 2009	2145 hrs	_
		 Facility Name (if not institution Philadelphia Road 	give street and	number)	4	b. City, Town Joppa	, or Locatio	on of Death		4c. County o Harford		
Funeral		5. Social Security Number	S. Sex	7. Age (In yrs.	last birthday)	If Under 1		nder 24Hrs	⊣		9. Birthplace (State or Foreign	
Director		010 00 7020	1XM 2F	40	Yrs.	Months I	Days Ho	urs Min	08/	13/1968	Country)MARYLAN	
any	H	Usual Residence of Decedent 10a. State 10b. County		Inc. City	y, Town or Location	n					10d. Inside City Lim	its
* .	_	,	ARFORD			JOPPA					1 X Yes 2	40
Maryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Coo				10g. Citizen of Wh		\neg
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her dez ", or i		3 Widowed 4 Divo	T es		1	Yes 2 X	No spec	ify:		Specify:	BLACK	
ours a	d by	15. Decedent's Education (Speci	fy only highest g	rade completed)	16a. Decedent	's Usual Occ				16b. Kind of Bus	siness/Industry	\neg
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5-003 fled within Hygiene. I other th	omp	12 17. Father's Name (First, Middle,	ast\		FOR	RK LIF				e, Maiden Surname)		
215-0036 be filed within 7 ntal Hygiene. rked offer than eut, the Medica	Be C	DAVID WORTHING	,	GAN SR.					MAY MO			ļ
21 should nd Mei is mail	2	19a. Informant's Name/Relationsh RACHELLE MORGAN		SE						umber, City or Town		
e, ME l and 2 s Health a item 27		20a. Method of Disposition		20b	. Place of Disposi	tion (Name o			Date		City or Town, State	
Baltimore, permit Pages Lar Department of Hee Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other Spi		from State R.	A. FERR		O, IN	c 2/	23/09	WEST	CHESTER, PA	
Baltimo permit Page Department of Important: injury or otl		21. Signature of Funeral Service I	icensee	^	22. N	ame and Add	ress of Fac	FUNER	AL HOM	E, P.A.		\neg
		23a. Part I. Enter the disease, or o	omplications the	Cemar the deal	7 '	552 T.E	WIS S	TRFT	'. HAVR	E DE GRAC	E, MD 21078 art Approximate Inter	val
Physician /Medical		failure. List only one cause	on each line.	l Neck Injurie		ie mode or dy	mig, odom c	.5 0412100	, , oop., c.o., c		Between Onset a Death	
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760, ficate be ex g physician the buriat	/Me	IF FEMALE: 23b. Was decedent pregnant in the		s, outcome of pre			2 East	opic pregn	2001	23d. Date of	delivery Day Year	
Box 68's death certificate attending	Physician	past 12 months?	4 Pre	e birth egnant at ti <mark>me</mark> of i	de edle	tal death ner <i>(Specify)</i>		opic pregn	ancy	Month	Day real	
Bo) e deatl the att	hysi	1 Yes 2 No 9 Unk	3 011	known					100.0			
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COT law re has b	Completed	-							pe	rformed?	prior to completion of cause death?	
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Vital Rec ysician: The his certificate) Be	examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		Other		ng Home 5	Residence 6	✓ Other: Scene	
1 of V	n: To	27. Manner of Death	28a. Da	ate of Injury onth, Day Year) 3, 2009	28b. Time of I	njury 28c	Injury at V	Vork?		oe how injury occurr o fixed object o		_
ion ttendi death. rtor: / the fi	atio	1 Natural 5 Pend 2 Accident Inves	tigation		2140 hrs		Yes 2					
Division of Vital Records, pital or Attending Physician: The law requirements after death.	Certification:		not be		home, farm, stree ad / Highway		fice building	g, etc.	or Town	n (Street and Numb n, State) elphia Road, Jopi	er or Rural Route Number, (pa, Md.	Jity
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri			vsician: To the	best of my knowle	edge, death occur	red at the tim	ne, date and	d place, an	d due to the ca at the time, da	ause(s) and manner ate and place, and c	r as stated. due to the cause(s)	
To t with To 1	Medical	29b. Signature and title of certifie	and manne	er stated.			cense num				ed (Month, Day, Year)	- 1
		DLM),L,n	M)		c	.C.M.E.			February 1	4, 2009	
6		30. Name and address of person Donna M. Vincenti, MI		ause of death (Ite		Penn Str	eet Balt	timore N	MD 21201			
	tate	31. Date filed (Month, Day, Year)	34.									_
Regis			009 12.	was A	ature park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lalbot memorial astor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 M 2 □ F 215-44-6533 Usual Residence of Decedent Director SAN. Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Westeal Examinar must be notified at once. 1 XYes 2 No Director MD. albot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral H/II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify ģ Black 3 ☐ Widowed 4 ☐ Divorced Health and Mental Hygiene. tem 27 Is marked other than "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Board of Education eacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. P. O. Bux 2354 Easton, MD. 2/60/ Herbert 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Richards Men, Park 2/16/09 Easton, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P.A. Henry Sic washington str Cambri 23a. Part t Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Non Small Cell disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-tran Due to (or as a consequence of): physician the burial Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? H1V1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ∐ Yes 2 **N**No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

death with the Maryland

filed within 72

and 2 should be

Pages 1

バリルン といし Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

Donnett

31. Date filed (Month, Day, Year)

FEB 13

MY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

37. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Washington St, Easton, MD 21601

2-11-2009

			For State Registrar	State of N	/larylan		artment of rtificate o			lental Hyg	iene	009	068	74
*		57	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat	h	V	3. Time o	
	Physici /Medi		Emily	McLea	n		Morg	an		Month 2	Day 15	2009	1:15	Рм
	Examir		4a. Facility Name (If not institution,	give street and numbe	or)		4b. City, Town	, or Location	of Death		4c. C	ounty of Deat	h	
We see		÷.	1510 Mount Hermo	n Road			Salis	bury			W	icomic	0	
	Funeral Director		5. Social Security Number 438–58–3962	5. Sex 1 ☐ M 2 X F	Age (In yrs.	9 Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day, 5-25-1	Year) 919		hplace (State o buntry) rginia	or Foreign
	P.		Usual Residence of Decedent 10a, State 10b, County		10- 0:-	· *							10.1 1- 14. 0	(a. 1) (a.
	show	7	,			y, Town or Lo							10d. Inside C	2X No
	Me M	Director	MD Wicomi	co	Sa	alisbu					0= 0:4:	() \ / - \ / - \		
	with t	ä	10e. Street and Number				10f. Zip Cod			11		n of What Co	untry?	
	e 23	62	1510 Mount Hermo	n Road 12. Was Deceder	at Ever in II	c 12	Was Doordook	21804		noify Voe or No-		SA . Race - Ame	rican Indian	
21215-0036	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examined countries in the medical Examined in the interpretation of the countries of the medical Examined in the medical Exami	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced.	Armed Force	§? ∑No		if Yes, specify C			ecify Yes or No- Rican, etc.)		Black, White		
Ŏ	2 ho	ted	15. Decedent's	Education		16a. Dece	dent's Usual Oc kind of work do	cupation	art of work		16b. Kind	f of Business/	Industry	
21	hin 7	pje	(Specify only highest Elementary/Secondary (0-12)	College (1-4c	ır 5+)	lifa.	DO NOT use ret	ired)	OST OF WORK	nig				
21	gien gien	Con	12			Bus	Driver	,			T	ranspoi	rtation	
	42 should be tiled within h and Mental Hygiene. 7 ie marked other then "traumatic event, the Men	Be (17. Father's Name (First, Middle, L.	ast)				18. Mot	her's Name	(First, Middle, N	Maiden Si	umame)		
/lai	Ments Ments arked		Kenneth	·	McLeai	1		Ade1	e			Doty	У	
Maryland	and la		19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Mailir	ng Address (Stre	eet and Num	ber or Rura	al Route Number,	City or 7	Town, State, 2	Zip Code)	
\S	and and n 27		Astor Morgan - S	on				atubba		et, Abei	deer	n, MS 3	3973 <u>0</u>	
Ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	W Bamoval from Sta	_	lace of Dispo emetery, crea	sition (Name of matory or other p	olace)	(Date	20c. Loca	ation - City or	Town, State	
Ĕ	Pag nent ant: h		4 Donation 5 Other (Spe			an Isl	and Com	. Cem.	2-21	-2009 1	Pecar	n Islam	nd, LA	
Baltimore,	permit. Pages 1 and 2 Department of Health at Important: If Item 27 ie eny injury or other trau <u>once</u> .		21. Signature of Euneral Service Li	censee	21 1	22	Name and Ad	dress of Fac	ility Bo	unds Fur	iera.	l Home	12.	
m	89 = 89	4	71 Jelissa	Spuy L	XOUR	Q 7	05 E. Ma	ain St	reet,	Salisbu	ıry,	Maryla	and 218	04
1	*		23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplication that caus	ed the deatl	n. Do not ent	er the mode of o	tying, such a	is cardiac o	or respiratory arre	est,		Approximat Interval Bet	e ween
	Physician		Immediate Cause (Final disease or condition	Chron	- 5	hatren	Tre,	Lun		DISCO	0		Onset and	Death
1	/Medical		resulting in death)	a	as a conseq	uence of):		-	1	00000				
Ш	Examiner		Sequentially list conditions,	b					J					
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8760,	ate b hysic the b	dical		d										
9		0	IF FEMALE:											
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1 ☐ Live birth	2 Feta	I death 3	Ectopic pregna				23	d. Date of deli Month	,	Year
	the a	sic	1 ☐ Yes 2 ☐ No	4□Pregnant 9□Unknown		eath 5	Other (specify)		-			TVIOITET	Duy	r eu
P.0	that the deed by the detached	Phy	9 Unkpown			Teta Con				and District				1
	res tha	þ	Part II. Other significent condition	contributing to death	but not res	uiting in the u	nderlying cause	given in Par	t I.	1			the cause of c	
Records,	w requir been si shoufd	Completed	Cavalo myos	214						Ye	s 2 🗌	No 3 Pr	obably 4 🗍	Jiknown
ec	as be	pie	Demontia	0						24a. Was an	2	prior to d	topsy findings completion of c	available ause of
<u> </u>	The ate h page	Son								autops periori 1 Yes 2	ZINO	death? 1 ☐ Yes	×	
'ita	stan: Brtitio	Be	25. Was case referred to medical examiner?					26. Pla	ce of Death	(Check only on	9)			
of Vital	ding Physician: The lav h. Atter this certiticate has tuneral director, page 2	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatier	IL SOUNT		Nursing Ho	me 5 Reside	nce 6 [Other (Spec	cify)	
0 0	ng P		27. Many er of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Da <i>y Ye</i> a <i>r)</i>	28b. Time o Injury	f 28c. Ir	york?		28d. Describe ho	w injury o	Derrupac		
Sio	uttendii death. ctor: A y the tu	cati	2 ☐ Accident Investiga	ition			M 1	☐Yes 2[□No					
Division	or Attending atter death. Director: Atte in by the tune	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Place of	Injury - At he etc. (Specify	ome, farm, str	eet, factory, office	Э		28f. Location (Str City or Town	eet and i , State)	Number or Ru	iral Route Num	iber,
D	To the Hospitel or Attenk within 24 hours after death To the Funaral Director: completely tilled in by the													
	Hospitel	icai	(Check only 2 Medical E	Physicien: To the be xeminer: On the basis	of examina	wledge, deat tion and/or in	n occurred at the	time, date a	and place,	and due to the ca	use(s) and p	nd manner as	stated.	;)
	To the Ho within 24 I To the Fu completely	Medicai	one)	and manner	stated.									
	To To		29b. Signature and title of certifier	1/1/	//	^	29C. Lice	ense numbe	. ~ -	7 5 25	od. Date:	signed (Mont)	i, uay, Year)	
	1001	19		M	,	M		06	2-	+8	0-	16-		
	K Par		30. Name and address of person w	no completed cause o	f death (Item	23a) (Type,	Print)	0	2 ,.	-y 7 ~	0	, ,	mD 2	18172
			DANNE. (OLL	ally MO C	restry	Ha	5/14 1	NO R	DOX/	+55 4	10/1	sty;	MIN A	100
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa	ture	parel					y		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:35 pm P006-01 Mary Louise Matthews /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tospillat the Willomico Sburu I Year I If Und If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2√F Months Days Hours Min Director 213-14-6207 Jan. 15. 1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, its Prodict Examinar must be notified at Director 1 Yes 2 No Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 6th Street 21851 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>ک</u> Specify: 3 Widowed 4 Divorced Black Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Board of Education Elementary/Secondary (0-12) College (1-4or 5+) Worcester County Instructional Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Bailey Nettie Wade McCov 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any Injury or other tra Harrison Matthews, Sr./husband 102, 6th Street, Pocomoke City, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gdn 02/16/2009 Hebron, Maryland 22. Name and A dress of Facility 1213 Jersey Road, Salisbury, MD nature of Funeral Service License JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYRLOWA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy for Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 2 - Ro 1 ☐ Yes of Vital 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: ဥ 1 | Inpatient 2 | ER/Outpatient 3 | DOA HOSPICE After this 27. Mapner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division or Attending Natural 2 Accident 5 Pending after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10058410 02/10/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL P.U. SUX 1733 SAWBUY UND 21802 a frugm wani HOSPICA 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 06876 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SAMUEL MAGEE SR. 8:30 PM FEB. 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F APR. 28, Director 221-28-2449 1944 DELAWARE Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f shov event, the Medical Examinar in ust be notified at Director 1 ☐ Yes 2 No DELAWARE SUSSEX SELBYVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36580 ROXANA ROAD 19975 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No If Yes, Give Year or Dates: Specify þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MAN HOUSING Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental WILLIAM MAGEE LOUELLA HALL ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUTH M. MAGEE/WIFE 36580 ROXANA ROAD, SELBYVILLE, DE. 19975 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROXANA CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 2/16/09 ROXANA, DELAWARE 21. Sign Jure / Funeral Service Licenses 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician orovary disease or condition resulting in death) 4 my /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be execute burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ó 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1 □ Yes 2 X No on of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38353 2-12-09 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, RENE L. DESMARAIS, MD, 400 EASTERN SHORE DR., SALIBURY, MD 21801 Year) 32. Registrar's Signature State 17 Registrar

ee,

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dav Year Eileen Mollett February 2009 3:55PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 130 Village Oak Drive Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours Director 542-16-0628 88 01/21/1921 Idaho Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show sdical Examiner must be notifled at 1 Yes 2 No Funeral Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 130 Village Oak Drive 21804 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Completed by Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 none Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H should be Albert Frammelt ပ Ann McKelvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heatth and Important: If item 27 is n any injury or other traun once. 130 Village Oak Drive, Salisbury, MD 21804 Roy Mollett/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02/20/2009 Salisbury, Maryland 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licenses 11673 Somerset Ave., Princess Anne, MD 21853 a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line Approximate Interval Between Onset and Death mmediate Cause (Final UK **Physician** disease or condition resulting in death) /Medical Due to (as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☑ Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00 25219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEGMAS EB 30434 Mt. Vernon Road, Princess Anne, MD 31. Date filed (Month, Day, Year) FEB 2 0 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryla	and / Dep <i>Ce</i>	artment of ertificate	f Health a	nd Mental Hy	/giene 0 0	9 06878
	Physici	an	Decedent's Name (First, Middle, Last))				2. Date of D Month		3. Time of Death
	/Medic			ZABETH MULLI	NS			Februa		
	Examin	ner	4a. Facility Name (If not institution, give				n, or Location of		4c. County of	
	5		Harford Memorial H 5. Social Security Number 6. Se		rs. last birthday		de Grad	4 Hrs. 8 Date of Bi	Harf	Ord Birthplace (State or Foreign
	Funeral Director]M 2∏F	86 Yrs.	Months Day		Min. 7/14/1	ay, Year) 922 P	ennsylvania
7	,		Usual Residence of Decedent					.,,,		CIZIBYTVAIILA
, alva	o d		MD Harford		City, Town or L berdeer					10d. Inside City Limits
M od	Sa-f	Director			mer deer					1 ☐ Yes 2 ☐ No
dia	0 4	급	10e. Street and Number 230 Baltimore St	reet		10f. Zip Code	• 1001		10g. Citizen of What	at Country?
U K I K I 3-0036 filed within 72 hours after death with the Maryland	78 23 Tales	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13			in? (Specify Yes or N		American Indian.
ية و			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No				in? (Specify Yes or N Puerto Rican, etc.)	Black,	White, etc.
3	E	d by	3X Widowed 4 □ Divorced	1 Yes 27 No tf Yes, Give Year or Dates:		1□Yes X□N	No Specify:		Specify:	White
ה ה ה	digital digital	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Giv	edent's Usual Oct e kind of work do DO NOT use ret	cupation ne during most o	of working	16b. Kind of Busin	ness/Industry
ig ig	hen.	d d	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)			ired)		171+1- C	
של ה ביים ביים	Hygie ther int, tr		17. Father's Name (First, Middle, Last)		VOIC	ınteer	18. Mother	s Name (First, Middle	Health Ca	are
	ked o	To Be	Loymon S. Mortorf	f				Norah I. N		
X	nd M mar	-	19a. Informant's Name/Relationship (Ty		19b. Mail	ing Address (Stre		or Rural Route Numb		ate, Zip Code)
E 6	alth a 27 is r tre		David R. Mullins/S	on				, Aberdeen		
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	ant: h		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	GIIIOVAI IIOIII SIAIB		lge Cemet		/2/2009	Delta, Pe	ennsylvania
	Department of Health and Menial Hygiene. Important: if item 23a or 28a-f ehow any Injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funefal Service Liouns	99		22. Name and Add				
u e	.O.5 = ol	Ш	23a. Part1. Enter the disease, or compl	tinson				Home, Inc		PA 17314
be executed	hysician and properties and the prival-transit properties and the prival-transit properties and the prival prival properties and the prival prival properties and the prival pr	al Examiner	shock, or heart failure. It is only or the mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):)				Interval Between Onset and Death
The law recoultes that the death certificate	been signed by the attending phy should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnal			23d. Date o Month	f delivery Day Year
oulres tha	en signed	þ	Part II. Other significant conditions cor	stributing to death but not r	esulting in the t	underlying cause	given in Part I.		_	te to the cause of death? Probably 4 Unknown
The law re	icate hes be r, page 2 sho	Completed						24a. Was auto perfo 1 Yes	psy prio ormed? dea	e autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \text{No} \)
Siciar	this certificate al director, pag	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	C. en ::		Other	f Death Check only		
5 &	r this	5	27. Manner of Death	28a. Date of Injury	☐ ER/Outpatie	III 3 DOA	4 🗆 Nurs	ing Home 5 Resi	how injury occurred	Specify)
gi G	th. : After funer	盲	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	V	vork? □Yes 2□No		now injury occurred	
or Atter	atter death. I Director: After this certificate he in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Special Control of the c	home, farm, st cify)				Street and Number own, State)	or Rural Route Number,
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurred at the	time, date and y opinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
Toth	To the	W	29b. Signature and title of certifier	1			ense number		29d. Date signed (A	fonth, Day, Year)
) a	L		DO	0632	20 PRACE, M	2/25	1/2009
			30. Name and address of person who co	mpleted cause of death (It	өт 23а) (Туре	Print)	- 1 /	1	1.	
			GEORGE ISCHARUS	501 S.UNI	ON AU	le HAVI	re de C	TRACE, M	107-2107-8	3
	Sta Registr		31. Date filed (Month, Day, Year) WAR 0 4 2009	2. Registrar's Sig	nature	Med				

2/10

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** 10:55 р February 11, James Joseph Norton Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4514 Bayne Street Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours **†X**M 2□ F 578-40-6771 MD Feb 2, 1927 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the "Moddal Exercitor rust be natified at Rockville 1 ☐ Yes 2 No Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 4514 Bayne Street 20853 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? 1 Yes 2 ☐ No Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 Is marked other than "natural", or iter 1 Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 27 Married Saltimore, Maryland 21215-0036 1 □Yes 2√√√ No Specify. Specify: White 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Revenue Officer Transportation 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Norton Mary Clifford 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. /Wife Maureen Norton 4514 Bayne Street, Rockville, MD 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Feb 17, 2009 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Maso 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metabolic Acidosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Dehydration attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Stage IV Metastatic Colon Cancer with Metastasis to Liver and Lung Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐No after death 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 29a, Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) and manner stated. within 2 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 10+1 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Suganthi Alagarsamy Veerappan 9000 Franklin Square Drive, Baltimore, MD 21237 2. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2009 Year **Physician** 9:25p M February 11, Snyder Betty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) Examiner Laurel Regional Hospital Prince George's If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Nov 14, (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace Country) **Funeral** Days Hours 1 □ M 2√2 F 82 1926 Director 577-32-9626 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it o Maxical Examiner must be notified at 1 ☐ Yes 217 No MD Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 404 Belton Road 20901 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Edison Snyder Frederica Thierbach Delano ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 i 14 Barn Ridge Court, Silver Spring, MD 20906 Carolyn Elaine deHaas /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 Removal from State Brentwood, MD Feb 16, 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 21. Signature Funeral Service Licenses 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease exacerbation **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician; The law requires that the death certificate be executed Respiratory Failure and burial-tra resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) the o detached 9 Unknown ₫. ned by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death? Dementia 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 2XXNo the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 😾 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death

12X Natural 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) npletely filled in by 4 ☐ Homicide 24 hours a Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier ۵ MD. Nywely D64760 February 12, 2009

DHMH 17 Rev 1/2001

State Registrar Mythily Vancha
31. Date filed (Month, Day, Year)

7300 Van Duesen Rd., Laurel, MD 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygieren 19

	=35		1 - For State Registrar	Otate of Maryl		rtificate of D		Reg	i. No.	
	Physici		1. Decedent's Name <i>(First, Middl</i> e, <i>Las</i> Leonor a	Z.		Nooks		2. Date of Death Month February	^{Day} , 2009	3. Time of Death 9:35 P.N
	/Medio Examir		4a. Facility Name (If not institution, given Sligo Creek Nursi			4b. City, Town, or L Takoma			4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 578-72-9464 1	7. Age (In)	vrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) December	9. Birth 6,1923Jama	place (State or Foreig ntry) ICA
pos	ž		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limit
N S	-f eho	tor	D.C.		Was	hington				1 ☐ Yes 2 ☐ N
with the	3a or 28a at be noti	ai Direc	10e. Street and Number 4702 5th Street,	N.W.		10f. Zip Code	20011	109	U.S.A.	ntry?
5-0036	Department of Health and Mental Hygiene. Important: or Items 23a or 28a-f show important: If Item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
CIZIS-UUSO	than "natu	mpleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th grade		16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired) Nannie	tion uring most of work	king	8b. Kind of Business/Ir Private	ndustry
7	and Mental Hygie a marked other t umatic event, to	To Be Co	17. Father's Name (First, Middle, Last) Bertie De		_		18. Mother's Nam	ne (First, Middle, Ma Hennie	uiden Sumame) Campbell	
ary	and M la mari	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street ar	nd Number or Rui	ral Route Number, (City or Town, State, Zi	Code)
	n 27 I		Joan R. Brown (Da			16th Aven				20912
Dallillor,	Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3			osition (Name of matory or other place,			c. Location - City or T	
o d	tant: jury		*4 □Donation 5 □ Other (Specify		eorge Wa	shington (Cem 2-21	-2009 A	delphi, Ma FUneral Ho	ryland
	Deparement in policy in procession of the proces		21. Signature of Funeral Service Licer	See					ngton, D.C	
E	hysician and //Medical as the parial-transit	Examiner	23a. P. 7. Enter the disease, or com sinck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Pneumoni	.a sequence of): Pressure sequence of):	Hydroceph				Approximate Interval Between Onset and Death
do / ou,	nysicia he bur	licai		d						
P.O. BOX 68/60,	ttendir or use	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 (Moo	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	Fetal death 3[□Ectopic pregnancy □ Other (specify)			, 23d. Date of deliv Month	ery Day Year
ŗ .	signed by the a	y Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	ınderlying cause giver	n in Part I.	23e. Did toba	cco use contribute to	he cause of death?
	n sign	ed by	stroke		_			1 ≹ Yes	2 □ No 3 □ Pro	bably 4 Unknow
The Factor	ate has b	Completed						24a. Was an autopsy performs	prior to co	opsy findings availab empletion of cause of 2 XNo
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,	Tot	W	29b. Signature and title of certifier	Degun	- 45	29c. License 45471	number		d. Date signed (Month, ebruary 10	
	3		30. Name and ddress of person who Yeheyis Negussie	·			14 ST1va	er Spring	Maruland	20910

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
FEB 1 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#5PERFh, G892,6/25/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 12:19 02 06 2009 Hal S. Nickel, Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Community Hospital Cheverly Prince Georges 5. Social Security Number 064-26-2978 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 1 M 2 □ F Months Days Hours Min. 08/29/1926 Ohio Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1K Yes 2 No Prince Georges Cheverly 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3012 Lake Avenue USA 20785 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) 4 Aeronautical Engineer NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hal S. Nickel, Sr. Genevieve Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14302 Hampshire Hall Court Upper Marlboro, MD 20772 Raymia Henderson - Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Cemetery 2/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD Approximate Interval Between Onset and Death Immediate Cause (Final Uro sepsis disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown While 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and P.O. Box 68760, attending physician for use as the buria signed by the aid Division of Vital Records, certificate has the control of the c To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii After this

Physician

Examiner

Funeral

Director

r items 23a or 28a-f show ther must be notified at

Pages 1 and 2 should be filed within 72 hours after death with t ann of Health and Mental Hygiene.

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Important: If ite
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Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner

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/Medical

10a. State

MD

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed 12 eur Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 5 Pending investigation 1 DNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

WAM BOURE 31. Date filed (Month, Day, Year) State

FEB 12 2009

Hor 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Feb 6, 2009

001 Hospital Drin Chevry MD 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 16, 2009 Morris OSBAND 9:23 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 7, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Brazii 150-07-7885 93 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 1 Ves 2 □ No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: white 1 ☐Yes 2 X No 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kate Cohen Max Osband 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 N. Watford Ct., Sterling, VA 20164 Maxine Fowler, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb. 19, 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rodef Shalom Cemetery Pleasantville, NJ 2009 21. Sign ture of Tymeral Pervice Line 39 Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Rarti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUO CARDIAL Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 100 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🕱 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Mapmer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
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Saltimore, Maryland 21215-0036

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Department of Health Important: If item 27 any injury or other to once.

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Hospital or Attending Physiclan: The law requires that the death certificate be executed funeral director, this After t within 24 hours after death

To the Funeral Director:
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31. Date filed (Month, Day, Year) State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

110 32 Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

18

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	e or iviaryiand	-		of Death		Re	g. Non	ng	06884
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	Examin	er	Shady Grove Adventist				lockville				ntgome	
	Funeral Director		5. Social Security Number 334-01-2539	7. Age (In yrs. las	st birthday) 92 Yrs.	If Under 1	Year If Under 2 Days Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day, 1y 20,	Year) 1916	COL	place (State or Foreign intry) inois
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_			Madhavi Hubbly, MI	9901 Me	dical		er Drive;	Roc	kville	, MD :	20850	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemirer must be indiffed at once.	by Funeral Director	8101 Connecticut Av 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in Armed Forces? 1 XYes 2 ☐ No If Yes, Give	n U.S. 13	3. Was Decedent of If Yes, specify Cul		? (Specify Ye's or uerto Rican, etc.)	No- 1	USA 4. Race - Amer Black, White, Specify: Wh	ican Indian, etc.
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_			30. Name and address of person who comple Dr. Santosh Gopal R	ane, 1906	Bellvie		oanoke,	Virginia	240	14	
	Stat Registra	٠ .	FEB 1 7 2009	3. Registrar's Sign	nature						

State of Maryland / Department of Health and Mental Hygiene 06886 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, 2^{Year} 2009 **Physician** 7:01^a M FEBRUARY O'NEAL ARTHUR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 24,1928 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 🕱 M 2 🗆 F 80 Tennessee Director 408-48-8939 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Expressioner is ust be notflied at 1 X Yes 2 No Director Suitland Md. Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 6011 Goodfellow Drive 20746 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: Black þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Private Health and Mental Hygide em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F Mary Johnston Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 20746 6011 Goodfellow Dr. Suitland, Md. Robert Wade / Nephew other 1 Department of Healt Important: If item 2 any injury or other Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 2-20-09 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signat ve of Funeral Service Liv Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC omplications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, hely one cause on each line. 23a. Part 1. Enter the disease, r shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** tate myocardial disease or condition resulting in death) /Medical Due to (or as a cons Juence of): **Examiner** ante Coronina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ De metri 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☑ No 2 □No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖸 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. the within To the 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005512V TEGRARY 13th 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1'a men 1325 Southern avenu SE Just 310 my Washington DC 20032 31. Date filed (Month, Day, Year) State 19 2009 Registrar

09-01564 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Prince 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 21, 2009 Year 0945 hrs Medical Examiner John William Prince 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Hyattsville 4922 LaSalle Road 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex **Funeral** Days Months Hours Director Country) Illinois 49 11/30/1959 1 X M 2 579-92-8898 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No DC N/A 28a-f show Washington urs after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 28a-must be notified at 5115 42nd Street, NW 20016 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Ăfrican 2X No Yes If Yes, Give Year Yes 2 X No specify: Specify: Widowed 4 Divorced American 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed ithin 72 hc College (1-4 or 5+) Elementary/Secondary (0-12) permit Pages I and 2 should be filed intin 72 permit Pages I and 2 should be filed intin 72 Important: If item 27 is marked other than 1 important: If item 27 is marked other than 1 mortant: The Marked other than 1 mortant in Marked other than 1 mortant in Marked other than 1 mortant in Marked other than 1 mortant in Marked other than 1 mortant in Marked other than 1 mortant in Marked other than 1 mortant in Marked other in Ma Baltimore, MD 21215-0036 Private 3 Security Guard 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas J. Prince Be Ilanita Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerry Prince/Brother 9982 Sherwood Farm Rd., Owings Mills, MD 20c. Location - City or Town, State Ja. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2 X Cremation 3 Removal from State Chesapeake Crematory 2/27/2009 Beltsville, MD Other Specify. Donation 5 22. Name and Address of Facility McGuire Funeral Service, Inc. ∠1. Signature of Funeral Service Licenses 7400 Georgia Avenue, NW Washington, DC nolro Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Medical Death Head injuries with complications Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Inopital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and transit Physician/Medical 23a,27,28a-f, perME, g889 3/30/09 TT AMENDED X UNPENDED ned by the attending physician detached for use as the burial -23d. Date of delivery IE EEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has death? performed? certificate Yes 2 ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? DOA Certification: To After City 29 (C

Funeral Director: To the

1 V Yes 2 No				
7. Manner of Death	28a. Date of Injury 28b. Time	of Injury 28c. Injury at Work?	28d. Describe how	injury occurred
Natural 5 Pending	(Month, Day, Year) Fd 2/21/09 Fd 0	940 hrs ^{1 Yes 2 X No}	unk	
Accident Investigation			205 1	
Suicide 6 X Could not be determined	28e. Place of Injury - At home, farm, s	street, factory, office building, etc.	or Town, State	eet and Number or Rural Route Number e) UN K
Homicide	(Specify)			
	To the best of my knowledge, death on the basis of examination and/or inves			
an	d manner stated.			
b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year)
Calina	40.	O.C.M.E.	F	February 24, 2009
Manua and address of assess who som	related source of death (Itom 22a)			

Assistant Medical Examiner Zabiullah Ali, M.D.

111 Penn Street, Baltimore, MD 21201

State Registrar

Medical

29

31. Date filed (Month)

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death - Month Day Mercer B. Prewett 12 TEB124AR Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. Abril 1, 1 BACTIMORE WASHINGTON MEDICAL TER ANNE AFUNDE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 170 M 2 □ F 82 219-16-1887 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Maryland Anne Arundel Annapolis 1⊠Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 148 Jefferson Street 21403 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Yes 2 No li Yes, Give Year or Dates: 1944–46 1 Never Married & Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Dealer Body and Fender Man 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude Prewett Mary Chafin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria Prewett/wife 148 Jefferson Street Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem. Gardens 2/18/2009 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses odd 147 Duke of Gloucester St., Annapolis, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2818 Due to (or as a consequence of): DNGESTEVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an 2 🗔 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760 attending physician as the b for use signed by the a Division of Vital Records, icate has been si certificate Physician; this

Examiner Physician/Medical \$ Completed Be Certification: To e Hospital or Attending F 24 hours after death. e Funeral Director: After completely filled in by the

Physician

Examiner

Funeral

Director

28a-f show

death v

Director

Funeral

þ

Completed

Be

ပ

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic contractions."

Physician

Examiner

/Medical

Baltimore,

/Medical

Medical To the within 2 State Registrar

FEB

6 ☐ Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type Print) Waspital drive en Bussie

20161

31. Date filed (Month, Day Year)

3 Suicide

29a, Certifier

4 Homicide

32. Registrar's

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 14 **Physician** Oscar Steven Powell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** tal Lannam

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Soughtry) | 1951 | Maryland Doctor's Community Hospital Prince George's 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 X M 2 □ F 213-56-4811 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location other than "natural", or items 23a or 28a-f show vent, the Weddeal Examples in this defeat 1√ Yes 2 No Completed by Funeral Director MD Prince George's Greenbelt 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20770 22 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 🎇 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unk) Oscar Spotswood Powell Anna Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Akin Drive Oklahoma City, Oklahoma 73149 Steven Powell/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Arundel Crematory 02/19/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box
MO1251Beverly L. Heckrotte, P.A. Clarksville 21. Signaty of Funeral Service Lice P.O. Box 784 arksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Liver Failure /Medical Due to (or as a consequence of): Examiner Cirrhosis of Liver Sequentially list conditions, it and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of that the death certificate be executed Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Alcohol Abuse 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 X Natural 1 ☐Yes 2 ☐ No nours after death.
neral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital c within 24 hours af To the Funeral D completely filled i 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO MBD 45660 (1)00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dpinder Singh, M.D. 14300 Gallant Fox La. Bowie, MD 20715

DHMH 17 Rev 1/2001

Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year FEB. **Physician** 9, ALLEN PROCTOR SAMUEL 1310 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **№** M 2□ F 577-38-0286 **Director** 20,1931 Wash. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maderal Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1- Yes 2 □ No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19651 Crystal Rock Dr., #11 20874 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery Co Elementary/Secondary (0-12) College (1-4or 5+) 9th Bldg Services Manager Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Proctor ပ Lena Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Marshall (Son) 17504 Georgia Ave, Olney, MD 20832 20b. Place of Disposition (Name of cemetery crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify) o)E Heaven Cem 2/19/09 Silver Spring, MD 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licerises 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation ours after death.

leral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AYYAD 10/10

Registrar

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

of Vital Records,

Division

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Uley Franklin Perdue 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Comica If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) B. Date of Birth (Month, Day, Year) 07/12/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min 11**X**M 2□ F 218-12-1424 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 733 Richwill Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 DYes 2 □ No 1 Never Married 2 Married If Yes, Give Year or Dates: Navy 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) agent real estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Uley H. Perdue Shockley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Perdue/wife 733 Richwill Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of Wicomico Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/17/2009 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARCINOMA PROSTATIC MALIGNANT Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes ZENo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Sther (Specify) HOSPICIZ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work?

1 □Yes 2 □No

DO058410

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at

filed within 72 hours after

Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.

Maryland

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Important: If item 27 is
any injury or other trau

Director

Completed by Funeral

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Examiner

sician and burial-transit attending physician for use as the buria signed by the a d be detached for page 2 should certificate

funeral director, After this

Physician/Medical Completed by Be Medical Certification: To

1 Natural 2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records, r death. within 24 hours after death

To the Funeral Director:
completely filled in by the 1

> State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & HUMAN WAR COASTAL HOSPICA 31. Date filed (Month, Day, Year)

5 Pending

and title of certifier

investigation

6 Could not be determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

UBOF 1733 Stab Buy us 21802 backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Je bruari SP M Anne Elizabeth Palmer 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🛛 F 241-36-9703 09/13/1919 Nashville, Tenn Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. P.G. Springdale 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3205 Hunting Horn Lane 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No 1 ☐ Yes 2X No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel H. Williams, Sr. Pansy Mae Weaver Baines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olomide Ogunlano/Son 4307 Northeast 70th Place, Gainesville, Fla. 32609 20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cem. 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 02/24/09 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ton & Sons Co., Inc. any RAM 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Could ray ofm disease or condition resulting in death) aphylacour purells Signe titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Emphe sema Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Day Yea 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ♣Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician and s the burial-trans attending p certificate has been signed by the rector, page 2 should be detached director funeral After after death | Director: / d in by the f filled in

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

"natural", or items

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnes.

Physician

/Medical Examiner

altimore, Maryland 21215-0036

the Medical Exar insert rust be notified at

Director

Funeral

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Physician/Medical

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Certification: To

Medical

1 Natural

2 Accident 3 Suicide

4 Homicide

(Check only

29a. Certifier

24 hours a within 24 ho

To the Fune

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State Registrar on obdellu

5 ☐ Pending investigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdella, MD 12200 Annapolis ld., Suite 229, Glenn Dale, MD 20769 lukemil

🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31 Date filed (Month, Day, Year)

29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funaral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23s or 28e-f show any injury or other traumatic avant, in Medical Examinar reserved.

Physician

/Medical

Examiner

Examiner

Physician/Medical

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Certification: To

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Registrar

DHMH 17 Rev 1/2001

Funeral Director

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		For State Registrar		(Certificate of	Death	R	eg. No.	2009	08891			
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amine	er	4a. Facility Name (If not institution, g				r Location of Death			4c. County of Death				
		5404 Odell R		e (In yrs. last birth		sville	9. Date of Birth			GEORGES			
eral ctor		218-82-2602	Months Days				Cou	place (State or Foreign intry) aryland					
_		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit											
any injury or other traumatic event, the Medical Experimet relation and once.	ō	MD Prince	Georges		Beltsvi	116				1.☐Yes 2☐No			
	Director	10e. Street and Number	deorges	10f. Zip Code				10g. Citizen of What Country?					
		5404 Odell F	Soad.	207	20705			J.S.A.					
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.			13. Was Decedent of H		ecify Yes or No-	14.	Race - Amer				
		1 ☐ Never Married 2 ☐ Married		lo			Rican, etc.)		Black, White,				
	ğ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 □ No	Specify:		Sp	pecify:Bla	ck			
1	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. [Decedent's Usual Occup Give kind of work done life. DO NOT use retire	oation during most of work	ing	16b. Kind	of Business/Ir	ndustry			
	m d	Elementary/Secondary (0-12)	College (1-4or 5	+)				τ.	T				
		12th 17. Father's Name (First, Middle, La	ot)		Homemak	18. Mother's Name	/First Middle		Iome				
	Be						a Wood	vialueli Su	mamej				
	٩	Frederick J		10h	Mailing Address (Street			r City or T	own State 7	in Codo)			
		19a. Informant's Name/Relationship											
		Barbara A. Yo	oung (Dauc		7818 Cros Disposition (Name of crematory or other pla				tion - City or T				
		15 Burial 2 ☐ Cremation 3 4 ☐ Ponation 5 ☐ Other (Spe	Removal from State		crematory or other pla t∤1 Mem P		///	Lan	ırel,	MD			
		21. Signature of Funeral Service Lig		ME IVa									
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850											
Ė		23a. Part 1. Enter the disease, or co	emplications that caused	the death. Do no	ot enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between			
ı		shock, or heart failure. List on Immediate Cause (Final				1				Onset and Death			
ı		disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of):								months			
ı				weeks									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Weene									
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		resulting in death) Last	Due to (or as	Due to (or as a consequence of):									
	dedical	,	d						-				
		IF FEMALE:	00-16	-4									
	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	3 Ectopic pregnan	☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			23d. Date of delivery Month Day					
1	Physician/	1 □Yes 2 🙀 No 9 □ Unknown											
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								the cause of death?			
	d by			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Ur				bably 4 \Unknown					
	Completed						24a. Was a	n s	24h. Were aut	opsy findings available			
	μď				autopsy performed?			prior to completion of cause of death?					
		25. Was case referred to medical				26 Place of Doct	1 Tyes		1 ☐ Yes	2 □No			
- 1	o Be	examiner?	Hospital:	ent 2 EB/Outr	oatient 3 DOA Oth	26. Place of Death	me 5 Resid		□Other (Coo	(6.1)			
	0: L	27. Manner of Death	28a. Date of Inju	ry 28b. Ti	me of 28c. Inju		28d. Describe h			119)			
1	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Day	r, rear) Inj		Yes 2 □No							
	ili	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	n, street, factory, office	eet, factory, office 28f. L		f. Location (Street and Number or Rural Route Number, City or Town, State)							
- 1	Certification:	4 Homicide building, etc. (Specify) City or Town, State)											
		29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exempler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	dica	29b. Signature and title of certifier 29c. License number						29d. Date signed (Month, Day, Year)					
	Medical	29b. Signature and title of certifier	1	/ //		D28920							
	Medica	29b. Signature and title of certifier	mol	uff	D2	8920		2/]	L7/09	, Day, Tear)			
	Medica	29b. Signature and title of certifier 30. Name and address of person with the control of the certifier and title of certifier and title	on completed cause of d	eath (Item 23a) (T		8920		2/]	L7/09	, Day, Tear)			
	Medica	30. Name and address of person with Surinder Sa	ingh, M.D.	7319	ype, Print) Hanover		ceenbel						
	e	30. Name and address of person wh	ingh, M.D.	1	ype, Print) Hanover		ceenbel						

State of Maryland / Department of Health and Mental Hygiene 06895 For State Registrar Reg. No. Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:08 AM ORIO FEBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner HDG ERSTOWN
If Under 1 Year | If Under 24 Hrs. CUNTO Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 💢 🕇 Yrs. 52 VIRĞINIA Director 11 1956 226-84-8734 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehror any Injury or other traumatic event, the Mentical Expension of the page 1. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 217 No **Funeral Director** BOONSBORO MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21713 U.S.A. 20913 SAN MAR ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No þ Specify: 3 Widowed 4 Divorced WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER AND OPERATOR BARBER & BEAUTY SHOP 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BETTY MARIE MAYS ပ WILSON MCNEER CHAFIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 20913 SAN MAR ROAD, BOONSBORO, MARYLAND KIM R. RHODES/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🗆 Burial Cremation 3 Premoval from State 2/25/2009 4 Don 5 Other (Specify) STAUFFER CREMATORY FREDERICK, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signatu e of Fung Paul M. Dean 7606 Old National Pike, Boonsboro, MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between 23a. Part 1'. Enter the dis Onset and Death Immediate Cause (Final 05486 **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of) Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) page 2 should be detached P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably Unknown 24b. Were authorsy findings available prior to completion of cause of death? 24a. Was afn autopsy performed Poten this certificate TOADMEN No. No 1 ☐ Yes ours after death. eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes Date of Injury (Month, Day, Year) 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) D005301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DH-25 E. 951 nS/19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

		•	For 1 ≤ State Registrar	State	of Maryland	•	artment of		and Mental Hy	giene Reg. No.	009	068	96		
			Decedent's Name (First, Midd	lle, Last)					2. Date of De	eath		3. Time o	of Death		
	Physici		Ruth M. Rosson						Februa	ry 16	, 2009	2:38	Р ^М		
	/Medic Examin		4a. Fecility Name (If not institution	on, give street and n	u <i>mber)</i>		4b. City, Town	n, or Location			ounty of Death				
	Examin	er	Crofton Care	-			Croft	on		Ann	e Arund	el			
	Euporal		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye		or 24 Hrs. 8. Date of Bi	rth	9. Birth	place (State	or Foreign		
	Funeral Director		064-30-1688	1□M 2ਊF	71	Yrs.	Months Day	ys Hours	Min. (Month, Di June 1			_York			
			Usual Residence of Decedent	1					i jourie .	2, 12.	57 TION	10111			
	ylan	To Be Completed by Funeral Director	10a. State 10b. Count	У	10c. City	, Town or Lo	cation				10d. Inside City Limits				
	a-fs		MD Anne Arundel				Odento	n				1 ∐ Yes	s 2X No		
	or 28		10e. Street and Number				10f. Zip Cod	ө		10g. Citize	Citizen of What Country?				
	d within 72 hours after death with the Maryland liene. r than "neturel", or items 23a or 28a-f show the Modreal Exploiter must be notified at		1007 Samantha Lane				211	13			USA				
	dea		11. Marital Status		cedent Ever in U.S	3. 13.	Was Decedent of	of Hispanic C	origin? (Specify Yes or Nan, Puerto Rican, etc.)	0- 14	Race - Ameri Black, White,				
9	or ite		1 Never Married 2 Married 1 If		es 2K∏No . Give		1 ☐ Yes 2 ☐ X /				Specify:				
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and	9 5 5 5 5		17. Father's Name (First, Middle						th A. Kelih		umame)				
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Maryland	12 st n and ris n		19a. Informant's Name/Relation						ber or Rural Route Numb) Code)			
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Andrea D'Enger	ns/Daugni			Gill S		Odenton,		I I I 3 ation - City or To	oum State			
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Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service	Licensee			2. Name and Ad		· beatt ru						
	402 6 4		6512 NW Crain Hwy. Bowie, MD 20715										ata.		
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complicated that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death												
			Immediate Cause (Final disease or condition resulting in death)	fn	cumoni	a						2 max	the		
		by Physician/Medical Examiner	rossining in south,	Due to	o (or as a consequ			1	and a consequence of the consequ			11	- 200		
			Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):								2				
	ted nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury)	<	(
	xecui and		that initiated events resulting in death) Last												
8760	ate be executed hysician and the burial-transit														
687	ate hy:			0.											
	certi nding sse a		IF FEMALE: 23b. Was decedent pregnant		utcome of pregnar					23	d. Date of delive	erv			
Вох	The law requires that the death certific tie has been signed by the attending p tage 2 should be detached for use as:		in the past 12 months?	Ectopic pregna Other (specify				Month Day Year							
Ö			1 Yes 2 (12) No 9 Unknown 9 Unknown												
9			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?									death?			
Vital Records,			Anenia Abdomual Acytic Aneurysm, 12 Yes 2 No 3 Probably 4 Unknow								Unknown				
2		lete	OSTEANNADI	trastu	Nes ADO	de	10.80	,	24a. Was	an	24b. Were auto	opsy findings	available		
Re	The lav	Completed	11400 10000	1 : 16	con al	04	Dia Fl			ormed?	prior to co death?	mpletion of	cause of		
a		C													
⋚	Physician: this certific ral director,	00	examiner?												
of		: To	27. Manner of Death	28a, Dat	e of Injury	28b. Time o		njury at Work?	28d. Describe			у)			
on	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification:	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ing (Mo tigation	nth, Day Year)	Injury		<i>N</i> ork? !∐Yes 2[□No						
Division			3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	ce of Injury - At hor	me, farm, st	reet, factory, offi	СӨ			Number or Rura	al Route Nur	nber,		
<u>S</u>		erti	4 Homicide	buil	ding, etc. (Specify,)			City or 10	wn, State)					
			29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	ne Hc n 24 ne Fu	edical	(Check only 2 Medice one)		basis of examinati inner stated.	ion and/or in	vestigation, in m	ny opinion, de	eath occurred at the time	, date and p	lace, and due to	o the cause(S)		
	To the within To the Comp	M	29b. Signature and title of certif	ier	Λ		29c. Lic	ense numbe		29d. Date	signed (Month,	Day, Year)			
			ParaIT	Muren	ril 1	ND	D4	4099	2	2/1	7/09				
4	Dadl	1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tara T. Muscovich MD 1438 Defense Hwy, Gambrills MD 21054 31. Date filed (Month, Day, Year) See 18 2009 See 18												
TaraT. Muscovich MD, 1438 Defer							rse Hw	4, Ga	Marills A	10 2	4054				
	Sta	ite	31. Date filed (Month, Day, Yea	r) 32.	Registrar's Signat	ure		J	/						
Registrar			FEB 1	8 2009 \	Eneura ,	D. A	arke								
DU	IAALI 47 Day 4/0	001		/											

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event

attending physician After this after death

Division or Vital Records, P.O. Box 68760,

Certification;

ca

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 🗓 O 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 3 ☐ Suicide

4 ☐ Homicide

29a. Certifier

6 □ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

29c. License number 46046 29d. Date signed (Month, Day, Year) 2 _ 26 - 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mirza-Alikhani 11711 Livingston Rd., Fort Washington, Md. 20744

State Registrar

To the Hospital within 24 hours a To the Funeral D

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 06898 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NORMAN FEB. 2009 8:55 P M RUST 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F JUNE 7, 82 DELAWARE Director 221-18-7569 1926 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits 10a. State 28a-f shov other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2X No Director MARYLAND WORCESTER SHOWELL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò , or items 23a 10129 PITTS ROAD 21862 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Deceden _. Armed Forces? 1 □Yes 2 📉 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 🛣No If Yes, Give Year or Dates: Specify: þ Specify: WHITE 3 ₩ Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed wire fleath and Mental Hygien tem 27 is marked other th MAINTENANCE WORKER FEED MILL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE RUST **EDITH** TOOMEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32475 SWAMP ROAD, DAGSBORO, DE. 19939 GERALD L. MITCHELL/COUSIN permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BISHOPVILLE CEMETERY 2/18/09 4 ☐ Donatien 5 ☐ Other (Specify) BISHOPVILLE, MD 21. Signature of Fundal Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician onaestive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a visual public cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) O 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To -to this Division of After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 2 Accident 5 Pending 124 hours after death.

Per Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. -12 (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00064120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atif Zeeshan 9733 Healthway Drive Berlin M.D 21811 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker FEB 17 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Feb 26, 2009 **Physician** 6:55am ^M Dorothy Irene Riehl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Golden Living Community Allegany Cumberland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ ₹ Oct 17, MD 213-22-3416 90 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show "natural", or Items 23a or 28a-f shov sdlcal Examiner must be notified at Cumberland MD Allegany 1 □ Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 13804 Bluejay Drive 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NX þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Branson Lease Hazel Lease ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11605 Woodruff Avenue Cumberland MD 21502 Patricia Harvey daughtei 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Oxemation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/26/2009 MD Cresaptown 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only dive cause on each line.

Immediate of use (Final disease or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the caus Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a conse vence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be execute and burial-tran Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 honths? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20000 certificate has page 2: 1∐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HS17) Ly Lin 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t Certification: 1-PTNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the nosponer within 24 hours after death.

To the Funeral Director: Af To the Hospital

> State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

one)

(Check only

M.D. 32 Registrar's Signature

and manner stated.

30. Name and address of persob who completed cause of death (Item 23a) (Type, Print)

GUPTA

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KENT AVE . CUMBERLAND, MD 21502 625

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DOU 33280

29d. Date signed (Month, Day, Year) Cels 26, 200 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2009 06900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Walter Roberson David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 27, 1955 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1 → M 2 □ F Months Days Hours Min 213-76-0045 53 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, I'm Medical Experimen must be notified at MD Allegany Cumberland Director 1 □ Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 365 21502 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes 2 □ N Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 🎦 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) laborer AC&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If them 27 is marked any injury or other traumatic ev Henry W. Roberson Dorothy L. Smith 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 413 Ridgeley WV 19a. Informant's Name/Relationship (Type. Print) David Roberson II son WV 26753 Ridgeley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 2/24/2009 LaVale MD 4 ☐ Donation 5 ☐ Other (Spegify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Se vice Licensee, 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one a see on each line. Approximate Interval Between Onset and Death immediate Cay e (Final disease or cardition resulting in ath) Acute myocardial infarction **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the cause of th Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Ö the 9 Unknown ò نه signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No After this certificate funeral director, page 1 □Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1X Natural 5 Pending To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State

Registrar

31. Date filed (Month, Day,

29b. Signature and little of certifier

SNOW

Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

009157

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month John William Schwegler Jr. 10:27 A M February 2009 16, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) 1 XM 2 □ F Days Hours Yrs 80 08/14/1928 109-22-1790 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Russell Avenue #801 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1946-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No 1948 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Schwegler Sr. Clare Theresa Etzel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Dorothy Schwegler (Wife) 403 Russell Avenue #801 Gaithersburg, MD. 20877 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Metropolitan Crematory Alexandria, VA. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licen 10 East Deer Park Drive Gaithersburg, MD. 20877 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) rell Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events (Ir as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy dent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy t 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 \square No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a, Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

death

72 hours after

t 2 should be filed with and Mental Hygier 7 Is marked other the

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is n any Injury or other traun

Baltimore, Maryland 21215-0036

Director

Funeral

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item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner is as the notified at

and physician ar s the burial-t attending for use as signed b Jas page certificate funeral director this 124 hours after death.

le Funeral Director: A pletely filled in by the fu death.

requires that the death certificate be executed

Hospital or Attending Physician: The law

To the I

Box 68760,

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Examiner Completer Be Medical Certification: To

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23b. Was dece
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autopsy performed? Yes 2 1 □Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

		referred to medical	
exa	miner?		
1	Yes	2 No	

27. Manner of Death 1 Natural 2 ☐ Accident

3 Suicide

(Check only

29a. Certifie

5 ☐ Pending investigation 6 Could not be determined 4 Homicide

Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifie

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MO 30. Name and ess of person who completed cause of death (Item 23a) (Type, Print)

Ničole S. Vetere M.D. 9901 Medical Center Drive Rockville, MD. 20850

State Registrar

31. Date filed (Month, Day, Year) FEB 18 2009



within 24 hou To the Fune completely fi

2+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2009

06902

			State Registrar		C	ertificate of	Death		Reg. No.			
			1. Decedent's Name (First, Middle, Las	st)		2. Date of Death Month Day Year A 3. Time of Death						
	Physicia		Dehorah	T. Sha	pard			Februa		2,2009	7 0339 AM	
-,	/Medic Examin		4a. Facility Name (If not institution, giv.	e street and number)	L/CI G	4b. City, Town, o	r Location of Death			County of Deat		
1	LAdiiiii	CI	Anne Arundel Med	ical Center		Annapol:	is		An	ne Arun	de1	
	Funeral		Social Security Number 6. S		(In yrs. last birthd	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth		hplace (State or Foreign	
	Director		217-66-6837	□ M 21X F 5	3 Yrs	Months Days	Hours Min.	(Month, D	1955	Pa	untry)	
			Usual Residence of Decedent									
	/lanc		10a. State 10b. County		0c. City, Town or						10d. Inside City Limits	
	Man	to	Md Anne Ar	undel	Crofto	on					XXYes 2 □ No	
	1 the	irec	10e. Street and Number	1		10f, Zip Code			10g. Cit	izen of What Co	untry?	
	3a o	<u>E</u>	1812 Sharwood	Place		21114	' +		U	SA		
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ev	er in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Orlgin? (Sp	ecify Yes or N	0-	14. Race - Ame		
ယ	ifter in the	F	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				nican, etc.)		Black, White	white	
Ö	al",o	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:			Specify: V	viiice	
21215-0036	72 hours after death with the Maryland 'natural'', or items 23a or 28a-f show deal Evan Incr. uet be notified at	Completed	15. Decedent's Ed	ducation		ecedent's Usual Occup		kina	16b. K	ind of Business/l	industry	
2	hin 7 e. an "r	g	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	`lii	fe. DO NOT use retire	d)	ung				
7	d wit gien	팃			Но	me Maker	·		10	wn Home		
b	be file Ital Hy Id oth event	Be (17. Father's Name (First, Middle, Last,)			18. Mother's Nam			,		
<u>a</u>	Ald b Alenta rked tic e	2	Clarence E	. Seidel			Betty (Catheri	ne M	iller		
Maryland	shol		19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street	and Number or Ru	ral Route Num	ber, City o	or Town, State, Z	žip Code)	
Σ	alth a		Steven Wayne She	epard	181	2 Sharwood	l Place	Crofton	, Md	21114		
ē,	othe othe		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	ce)	Date	20c. Lo	ocation - City or	Town, State	
٤	Page lent c nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Atlant	ic Cremato	ry 2/10	6/2009	Glei	n Burnie	, Md	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other traumatic event of the "doal Evanting or other Evant or other traumatic event of the "doal Evant or other traumatic event of the "doal Evant or other Evant or other Evant or other Evant or other Evant or other Evant or oth		21. Signature of Funeral Service Licer			22. Name and Addre						
m	permi Depa impo any ir		(ill dans			Robert E	Evans I	Tuneral	Home	(1 0071	-	
			23a. Part 1. Enter the disease, or com	plications that caused th	ne death. Do not	enter the mode of dyi	mapolis I	or respiratory	arrest,	4d 2071	Approximate Interval Between	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1201	Antron	DISER	14 15		1	Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to for as a	conseque : e of):	ARTERY	DISER				12 M/13	
	Examiner		7-11	Due to (or as a	ooriooquo Lo oi).							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):							
	uted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury									
	n and	Exa	resulting in death) Last	Due to (or as a	consequence of):						_	
68760,	e law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-transit			~ d.								
89	ificat g phy is the	Medical										
*	ndin use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				- 1	23d. Date of del	ivery	
Bo	death ie atter id for u	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal death me of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	cy			Month	Day Year	
P.O.	the o	λ	9 ☐ Unknown	9 Unknown								
	The law requires that the ate has been signed by the bage 2 should be detache		Part II. Other significant conditions of	contributing to death but	not resulting in th	e underlying cause giv	ven in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?	
ds	quires n sig	d by	DM	HTN				1 🗆	Yes 2	□ No 3□ Pr	obably 4 🔀 Unknown	
S	v red bee	Completed						24a. Wa	s an	24b. Were au	topsy findings available	
Be		ם						aute	opsy formed?	prior to death?	completion of cause of	
a			OF Man ages referred to madical	r			00 Di (D	1 ☐ Yes		1 ☐ Yes	2 No	
₹	Physician: this certific ral director,	8	25. Was case referred to medical examiner?	Hospital: 🔏	- T-0:4	Oth	26. Place of Dea			66		
oţ		은	1 Yes 2 No	28a. Date of Injury	2 ☐ ER/Outpa	ment 3 DOA	4 LI Nursing H	ome 5 Hes		6 ☐Other (Spec	cify)	
n	Attending r death. ector: After by the fune	ë	1 ☐ Natural 5 ☐ Pending	(Month, Day,	<i>Year)</i> Inju	ry Wor	rk?]Yes 2 □ No	234. 2337.134		,, 555454		
<u>.s</u>	tten deatl ctor: / the	ical	3 ☐ Suicide 6 Could not b		/ - At home, farm	, street, factory, office	7700 2 2.110	28f. Location	(Street ar	nd Number or Ri	ural Route Number,	
Division of Vital Records,	or A after Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	,,,,		City or To	wn, State	9)	rai i rosto i rainzon,	
_	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	S S	29a. Certifier 12 Certifying PI	hysician: To the best of	my knowledge. d	leath occurred at the t	ime, date and place	e, and due to th	e cause(s	s) and manner as	s stated.	
	24 h 24 h Fun etely	ledical		miner: On the basis of e	examination and/							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	۸		29c. Licens	se number		29d. Da	ite signed (Monti	h, Day, Year)	
	F > F 0		X Xmus M	Supplem	M.0	000	54739		Fah		74 2 5 - 9	
	,		30. Name and address of person who	completed cause of dec	ath (Item 23a) /Tu	pe, Print)	, , _ /		1001	ruary 1.	-, 2007	
	Sw		7845 DAKWOO	DRD Ste	2-44 6	- 1 R.	e Mrz.	VI-DE	Da	JOIA FILE	:04 EL	
	Sta		31. Date filed (Month, Dav. Year)	32. Registrar	s Signature	=11007111	C-1111)XIL	doj VK	ועעי	WIT COL	7	
	Regist			109 /2	. 4	ha. V. I					1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February Robert R. Snavely /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 7/19/1916 Birthplace (State or Foreign Country) 1 M 2□F Months Days Hours Min. 140-09-8018 92 Lancaster, PA Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Director MDAnne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 Greenbury Point Road 21409 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 1.7.7.7.7.7. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White þ Year or Dates: WWII Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Cameraman Assistant Elementary/Secondary (0-12) College (1-4or 5+) Motion Picture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rodney Snavely Anna ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Bowne Daughter 107 Greenbury Point Road Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/20/09 Whiting Memorial Park Whiting NJ 4 ☐ Donation _ 5 ☐ Other (Specify) Signature of Euneral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave ANN, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🌠 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 ppatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner as the burial-transi Exami and Records, P.O. Box 68760 the attending physician hed for use as the buria Physician/Medical be detached signed by δ this certificate has been a al director, page 2 should Completed Division of Vital Hospital or Attending Physician: Be P completely filled in by the funeral Sober After Certification: hin 24 hours after death the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of cer 29c. License number ٥ 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3 1

State Registrar

KUF

31. Date filed (Month, Day, Y

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinat must be nothered.

and Mental Hygiene.

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur

should be fi and Mental F

filed within 72 hours after death

Baltimore, Maryland 21215-0036

V

32. Registrar's Signature

		1	1 _ State	partment of Health and l ertificate of Death		ene g. No. 2009 - 06901		
	Physicia		1. Decedent's Name (First, Middle, Last) Barbara Jane Smith		2. Date of Death Month February	3. Time of Death		
C,	/Medic Examin		4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death		4c. County of Death Anne Arundel		
	Funeral Director		5. Social Security Number 163-34-8799 G. Sex 1 M 2 F 66 Yrs Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, March 1,	9. Birthplace (State or Foreign Country) 1942 Pennsylvania		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modifiel Examination to the profiled at once.	Director	10a. State 10b. County 10c. City, Town or Maryland Anne Arundel Annapol: 10c. Street and Number 1101 R Bay Ridge Avenue			10d. Inside City Limits XXXYes 2□No 1g. Citizen of What Country? nited States		
9800	hours after deal ural", or items	by Fu	1 □ Never Married 2 ▼ Married 1 □ Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 □ Yes 2 ▼ You Specify: secedent's Usual Occupation	to Rican, etc.)	Black, White, etc. Specify: White		
Maryland 21215-0036	ed within 72 /giene. er than "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	ive kind of work done during most of wor e. DO NOT use retired) Legislative Aide	rking	6b. Kind of Business/Industry State Government		
ryland	nould be file d Mental Hy π arked oth matic event	To Be	17. Father's Name (First, Middle, Last) Glenn Smith 19a. Informant's Name/Relationship (Type. Print) 19b. M	18. Mother's Nar Ida Mar ailing Address (Street and Number or R.		, , , , , , , , , , , , , , , , , , ,		
re, Mai	s 1 and 2 sh f Health an tem 27 is r other traur		Reverend John T. Smith / Husband 1101 20a. Method of Disposition 20b. Place of Di	R Bay Ridge Ave.	Annapol:	is, Maryland 21403		
Baltimore,	permit. Pages Department o Important: If i any Injury or once.	1	1 ☐ Burial XM Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Specify Baltimor	e Crematory 2/17 22. Name and Address of Facility Jo	hn M. Tay	altimore, Maryland lor Funeral Home, Inc. Annapolis, MD 21401		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Therefore to the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	enter the mode of dying, such as cardia Preumonitic		i		
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
P.O. Box 6	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year		
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to the cause of death? s 2 (Unknown		
al Reco		Completed	DVT		24a. Was ar autops perform 1 □ Yes 2	y prior to completion of cause of death? 1□Yes 2□No		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day, Year) 28b. Time (Month, Day, Year)	atient 3 DOA Other: 4 Nursing	ath (Check only one Home 5 ☐ Reside 28d. Describe ho	nce 6 Other (Specify)		
Divis	7 £ £ c	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		City or Town			
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical	29a. Certiffer (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, condition and form one) 1 ☑ Certifying Physician: To the best of my knowledge, condition and form one of the basis of examination and form one of the basis of the basis of the basis of the basis of the basis of examination and form one of the basis of	geath occurred at the time, date and place or investigation, in my opinion, death occurred 29c. License number	curred at the time, do	ause(s) and manner as stated. ate and place, and due to the cause(s) 9d. Date signed (Month, Day, Year)		
D	and	1	30. Name and address of person who completed cause of death (Item 23a) (Ty			2-14-2609		
	St. Regist	ate	31. Date filed (Month, Day, Year) FEB 17 2009 Segistrar's Signature	barks	SMO	21401		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (Figst, Middle, Last) 2. Date of Death **Physician** 0635 Februar 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b., City, Town, or Location of Death 4c. County of Death **Examiner** CUNIU DG ERS OWN WOSHINGTON 110 WOSTINSION If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 □XF Hours Yrs 214-09-4660 Director 95 19,1913 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2□No Director Marvland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Guilford Ave. 21740 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Be Completed by 3 ☐Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Ragan Alsip ၉ Nora Emily Bidle Alsip Shingleton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence A. South, III-son 617 Guilford Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 2-20-2009 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or com, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (ereBrovoscu 1100 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> HUDERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? SZÍNo 1 □Yes 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DINO 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) HAGESTONIN DNIM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Lighth and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14 Aces **Physician** Sigler Macie eloria /Medical County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number), Examiner Farhney-Keedy Memorial Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 213-12-7179 89 777 84 1°91 9 1 □ M 2 🛣 **Director** Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 ☐ No MD Frederick Director Middletown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 206 W. Main St. 21769 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X** X o If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: Completed by White 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 seamstress shoe co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance 7 is marked o Samuel Crone Annie Sarah Bowlus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Great (Niece) Dixie Eichelberger 206 W. Main St., Middletown, MD Health # 27 Department of Heat Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of pisposition Pages ' 2 Cremation 3 Removal from State ion 5 Other (*) 1 Buylal Locust Valley Cem. 2/18/2009Middletown, MD 4 □ Donation nture of pineral Se ²DonaldddB farllompson Funeral Home POB 18, Middletown, MD 21769 Approximate Interval Betweer Onset and Death Ent r the disease, or comp ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ementyd حما /Medical Due to (or as a consequence of) Cardvovasular Disense **Examiner** o (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER POPPE be executed burial-trar Due to (or as a consequence of) physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☐No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : certificate has autopsy performed Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 PNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 Division or \ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 **A**atural 2 **A**ccident 5 ☐ Pending investigation Subject fell. 01/06/09 1 ☐ Yes 2 X No 10:00 a M death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number of Bural Foute Number, City or Town, State) 8507 Mapleville Rd, Boonesboro, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Nursing Home 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number Doll 205 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02-16-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 1700) 580 NOTHERN AUG 1126 OPLL CT. HAGERSTON MD DR HOWLED WEEKS Witseton

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

					Maryland /Lusp per me, g889, Ce	737137655 rtificate of L	eaith and iv Death	rientai Hygi	ene g. No. 2009	06908			
-	Physicia		1. Decedent's Name (First, Middle RYAN J. SIN					2. Date of Death Month FEBRUARY		3. Time of Death			
L.	/Medic Examin		4a. Facility Name (If not institutio		ber)	4b. City, Town, or	Location of Death		4c. County of Death				
ار			311 ELM AVENUE			EAST	ON		TALBOT				
	Funeral		5. Social Security Number		. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, FEB 25	9. Birth	place (State or Foreign intry)			
700	Director		215-08-1558	1 X M 2 □ F	23 Yrs.	mentilo Bayo	Tiodio IVIII.	FEB 25 1		RÝLAND			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
	laryla sho	5		ALBOT	EAST					1 XYes 2 □ No			
	the N	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Country?				
	with a or					· ·	1.601	109		•			
	eath	era	311 ELM AVENUE	12. Was Decede	ent Ever in U.S. 13.		1601 spanic Origin? (Spi	ecify Yes or No-	14. Race - Ameri				
"	be filed within 72 hours after death with the Maryland nta! Hygiene. I had "natural", or items 23a or 28a-f show event, the Medical Exeminer must be notified at	Funeral	1 ☐ Never Married 2 ☐ Mar	Armed Force	No l	Was Decedent of His If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, White,				
036	urs a	by	3 ☐ Widowed 4 X Divorced	If Yes Give		1 □Yes 2 X □No	Specify:	Specify: WH	II T E				
21215-0036	72 hou	Completed	15. Deceder	nt's Education		dent's Usual Occupa		16b. Kind of Business/Industry					
21	within 7 iene. than "r	gu	Elementary/Secondary (0-12)	College (1-4	life.	kind of work done d DO NOT use retired)	uring most of worki)	ng					
21	ed wil	္ပ	9	0		SHIER			FOOD SERVI	CE			
nd	be filed Ital Hygi d other event, I	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Name	e (First, Middle, Ma	aiden Surname)				
yla	ould be Menta Iarked Iatic ev	၉	UNKNOWN				MARIAN	BITTING	-				
Maryland	2 sho tand ism		19a. Informant's Name/Relations		1				City or Town, State, Zi	code)			
	s 1 and of Health item 27 other to		MARIAN SINCLAI	.K/MOTHEK					AND 21601				
100	Pages 1 and 2 should nent of Health and Mer int: If item 27 is marke iry or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation	3 🗖 Removal from St	are i	matory`or other place	e) ¦		0c. Location - City or To	own, State			
ţ	t. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (S	Specify)	CHESAPEA	KE CREMAT		2-15-09	STEVEN	SVILLE, MD			
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	mERCE	_ F	2. Name and Addres ELLOWS, H OO S. HAR	ELFENBEIN	N & NEWNA EASTON.	M FUNERAL MD 21601	HOME PA			
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau	ter the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition			Onset and Death							
	/Medical		resulting in death)	Due to (or	s a consequence of):	770			_) minus			
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	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of);								
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ő,	oe ex	ũ	resulting in death) Last	Due to (or	as a consequence of):								
68760,	tificate be executed Ig physician and as the burial-transit	edical		d									
	ding se as		IF FEMALE:	23c If was outco	me of pregnancy								
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2☐ Fetal death 3☐	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year			
o.	he de hed	Physician/N	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknow		Other (specify)							
σ.	that the ed by detac		Part II. Other significant conditi	ons contributing to deat	th but not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to t	he cause of death?			
Division of Vital Records,	uires sign d be	d by	Ethans	and	1 subst	ance	abace	1 □ Yes	2 2 No 3 □ Pro	bably 4 ☐ Unknown			
00	w req	lete	hickary					24a. Was an	24h Were aut	opsy findings available			
Re	ne lav e has ge 2	Completed	1001019					autopsy performe	prior to co	ompletion of cause of			
ā	in: Ti ificati or, pa		25. Was case referred to medica	1				1 □ Yes 2√	No 1 ☐ Yes	2 X No			
5	Attending Physician: The law requires that the death ce r death. sctor: After this certificate has been signed by the attendiby the funeral director, page 2 should be detached for use	Be c	examiner?	Hospital:	patient 2 ☐ ER/Outpatier	ot 3 DOA Othe	26. Place of Death						
of	y Phy er this eral c	Ë	27. Manner of Death	28a. Date of	Injury 28b. Time o	f 28c. Injury	at	28d. Describe how	ce 6 Other (Speci	<i>ly)</i>			
on	th.: After	Ę	1 ☐ Natural 5 ☐ Pendir 2 ☐ Accident investi	Foundate, gation 02/11/		M Mork?	? /es 2 X /No		hanged sel	.f			
/isi	Atter r dea ector by the	iţi	3 Spicide 6 □ Could 4 □ Homicide determ	not bo	Injury - At home, farm, str , etc. (Specify)			28f Location (Stre	et and Number or Run	al Route Number			
Ö	al or s afte al Dir	Certification: To	4 🗆 Homicide	building	Garag	e	F	City or Town, Caston, MD	State) 311 Elm	Avenue			
	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one) 1 Certifyii Medical	ng Physician: To the be Examiner: On the bas and manne	est of my knowledge, deat is of examination and/or in r stated.	h occurred at the tim vestigation, in my op	ne, date and place.	and due to the cau	use(s) and manner as	stated. o the cause(s)			
	To the within To the complete	Me	29b. Signature and title of certifie		1	Mu 39c. License	number	290	d. Date signed (Month,	Day, Year)			
			Mary	Chille	~ Brands	n. 19	0176	3	02 14	2009			
			30. Name and address of person	who completed cause	of death (Item 23a) (Type,	Print)							
			Pavid C. Br	andon 1	no ,841	64 Avel	ey Farm	Rd, E	aston m	2009 d 21601			
	Sta		31. Date filed (Month, Day, Year)		istrar's Signature	. 1							
	Registr	al	FFR 1.7	ZUUS ///	100 1 M. 186	West of the second							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** WILLIAM E. STEWART /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER CAMBRIDGE DORCHESTER GENERAL HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Hours 1945 MARYLAND 1 X M 2 F Yrs MAR 6, 63 Director 218-40-6284 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director SECRETARY MD DORCHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21664 119 POPLAR ST Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 16h Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) GOVERNMENT permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnother poince." College (1-4or 5+) Elementary/Secondary (0-12) PRINTING OFFICE LITHOGRAPHER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (VIOLET EMMA RUE JAMES THOMAS STEWART, JR. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PO BOX 533, SECRETARY, MD 21664 NANCY L. STEWART/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/17/2009 HURLOCK, MARYLAND VETERANS CEMETERY MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 JOHN Z MERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final System **Physician** disease or condition resulting in death) /Medical Examiner Suprentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-t P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day Month Year 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by U 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy this certificate 1 □Yes 2 NO 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ♣ patient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

I Director: After to a in by the funeral (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mogth, Day, Year)

State

Registrar

TLS 1+VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

209 ene Newmier DD 321 N

FEB 1 2 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician REVA PAULINE SARD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** amb 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🛚 F 74 214-32-5138 Yrs OCT. 30, 1934 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show the Medical Exeminer must be notified at DORCHESTER CAMBRIDGE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 USA 525 GLENBURN AVENUE Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: <u>S</u> Specify: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicanone. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be REVA HOPKINS CHARLES FRANCIS LAYTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25605 LOBAU DRIVE, DENTON, MD 21629 ROGER LAYTON / SON 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buria! 2 ☐ Cremation 3 ☐ Removal from State 2-19-2009 JR. ORDER CEMETERY PRESTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 Strouds Joseph 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Dulmondry /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 XNo Month 5 Other (specify) 9 Unknown

P.O. Division of Vital Records,

or Attending Physician: The law requires that the death certificate be executed death. ieral Director: A filled in by the fu

þ

Completed

Be

Certification: To

Medical

25. Was case referred to medical

examiner' 1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

within 24 hours a State

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number

💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

1 Tes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28I. Location (Street and Number or Rural Route Number, City or Town, State)

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

hour

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

23e. Did tobacco use contribute to the cause of death?

autopsy perform 2 No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

1 🗌 Yes

26. Place of Death (Check only one)

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

1 X Yes 2 ☐ No

MARYLAND

WHITE

Name and address of person who completed cause of death (Item 23a) (Type, Print) Bramble St 100 Patricia

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

31. Date filed (Month, Day, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 5:38 pM Myrtle Estelle Sickmen 2009 February 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery General Hospital Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 F 95 March 22, Virginia Director 578-26-8217 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nortified at 10d. Inside City Limits 10c. City, Town or Location 10h. County 1 ☐ Yes 2 No Director Derwood Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20855 U.S.A. 18416 Azalea Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Luhmann - Daughter 18416 Azalea Drive, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 02/19/2009 Olney, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc.
11800 New Hampshire Avenue, Silver Spring, Maryland 20904 21. Signature of Funeral Service Licensee Myclin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ardiac /Medical Due to (or as a consequence of) Examiner hleroschoch Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the at d be detached fo P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ₹R/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

2

Medical

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

14/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 MD

State Registrar 31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 16, 2009 Schechter 530 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death and Rehab Montgomery Arcola Nursing Silver Spring If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12/18/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Min. Months Days Hours 579-38-4553 83 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1XIYes 2 No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20901 857 Loxford Terrace United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 X Married WW II 1 ☐ Yes 2 🗓 No White If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wine and Liquor College (1-4or 5+) Elementary/Secondary (0-12) Retail Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leah "Unknown" Chaskel Schechter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 857 Loxford Terrace Silver Spring MD 20901 Shirley Schechter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/17/09 Judean Mem. Gardens Olney, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 21. Signature of Funeral Service Licensee 20852 MO1163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 years Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ XNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 💢 No 1 ☐ Yes 2 🕅 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau
once.

Physician

Examiner

Funeral

Director

28a-f shov

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death

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Modical Examina. must be notified at

/Medical

physician and s the burial-trans attending pl certificate has been signed by the rector, page 2 should be detached ours after death.
neral Director: A
filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician/Medical <u>ک</u> Completed Be

Examine Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

To the Hospital within 24 hours a To the Funeral C completely filled

Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural
2 Accident 5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29d. Date signed (Month, Day, Year) 29c. License number D09834

2/16/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum MD 3720 Farragut Avenue Kensington MD 20895

State Registrar

Medical

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Katharine M. Slaughter 18, 2009 20:40 PM February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Hospital of Cecil County E1kton Cecil 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1 ☐ M 2 🗓 F Director 255-62-9553 19, 1922 Virginia Sept. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at Director Maryland Ceci1 1 ☐ Yes 2 No E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1783 Old Elk Neck Road E1kton United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Completed by 3 √Z Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be f f Health and Ments Item 27 Is marked Roy Christopher McCarter ဥ Fannie Bell McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dr. Frank Slaughter / Son 1783 Old Elk Neck Road, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot February 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 19, 2009 Mayerdale Crematory Newark, Delaware 21. Signature of Funeral Service License 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unknown aute Dou /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached for 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one examiner? 2 1 Yes 1 opatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) М 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours e To the Funeral I To the Hospitel 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO 4823 Am ce 132 UP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) west main JU MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 9 2009 Registrar

		,	1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	partment o		and Mental	Hygien Reg. N	2000	06914	
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Harry A. Stewi	art give street and numbe		4b. City, Tow	n, or Location	of Death	your	25 200° c. County of De	ath 0900 M	
ad'	Funeral Director				Age (In yrs. last birthday 86 Yrs.	/) If Under 1 Ye Months Da		24 Hrs. 8. Date Min. 04-2	of Birth th. Day Year 7-1922	Alleg 9.8 Mc	irthplace (State or Foreign Country) Coole, MD	
	the Maryland 28a-f show	ector	10a. State 10b. County Miner		10c. City, Town or L Keyser		No.		100.0	Citizen of What C	10d. Inside City Limits 1 Yes 2 No	
	23a or	al Dir	Rt. 4 Box 119 V	2		10f. Zip Cod 26726	16			10g. Citizen of What Country? United States		
21215-0036	d 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 71s marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedfool Even than could be redified at	d by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force d 1 []Yes 2[If Yes, Give Year or Date:	\$? XNo	. Was Decedent If Yes, specify 0 1 □ Yes 2 🛣		igin? (Specify Yes n, Puerto Rican, et	or No- c.)	nerican Indian, ite, etc. JHITE		
215-(iin 72 h i. n "natu Medico	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4c)	(Giv	edent's Usual Oc re kind of work do DO NOT use re	ccupation one during mos tired)	t of working	16b.	Kind of Business	s/Industry	
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⊆ .	should be fi and Mental H s marked ot umatic ever	To Be	17. Father's Name (First, Middle, La James B. Stewart	·			Mary	E. Tayl	or			
യ്	l and deal		19a. Informant's Name/Relationshi Caroline L. St 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ⚠ Donation 5 ☐ Other (Spe	ewart □ Removal from Sta	Rt. 20b. Place of Dispose cemetery, critical	4 Box 1	19V2 K	er or Rural Route I Eyser, W Date 02-26-09	V 2672		r Town, State	
Baltir	permit. Pages 'Department of I Important: If ite any Injury or of once.		21. Signature of Funeral Service Li			22. Name and Action	ddress of Facilit	by P.	O. Box		-	
	Chysician and bhysician and bhysician and bhysician and the printing t	ical Examiner	23a. Part 1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence of): as a consequence of): as a consequence of):	My CP	dying, such as	Cardiac or respirat	SSA		Approximate Interval Between Onset and Death ON CONTROL	
O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 Fetal death 3 It at time of death 5	☐ Ectopic pregn			_	23d. Date of d	elivery Day Year	
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f Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yo	Hospital:	atient 2 ☐ ER/Outpati	ent 3 DOA	Othor:	e of Death <i>(Check o</i> ursing Home 5 □		6 ☐Other (Sc	ecify)	
	ding h. After fune	Certification: 7	27. Manner of Death 1	tion t be 28e. Place of	Day, Year) Injury Injury - At home, farm, s	М	Injury at Work? 1 ☐ Yes 2 ☐	No 28f. Local	cribe how injudication (Street a	ury occurred	Rural Route Number,	
ă	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		4 🗆 Homicide	building,	etc." (Specify) est of my knowledge, dea	ath occurred at th	ne time, date a		or Town, Sta		as stated	
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical E. one)	xaminer: On the basi and manner	s of examination and/or	investigation, in r	my opinion, dea	ath occurred at the	time, date a	nd place, and du	ue to the cause(s)	
	5 1 2 2 3 3 4 3	2	29b. Signature and title of certifier	0 20	1	29c. Lic	ense number	-	29d. D	ate signed (Mor		
			30. Name and address of person w	ho completed cause of	of death (Item 23a) (Type		0101)	Iteb	ruary.	20,2009	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	strar's gignature	Vrive	Cur	nberlau	nd,	<u>170.</u>	L130Z	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrer Amend#4a.PerPhys.PCC2-12-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year February 2009 1:45p Almyra Sorre11 Facility Name (If not institution, give street and number) 321 Flag Harbor Blvd. 4b. City, Town, or Location of Death 4c. County of Death Calvert Leonard If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 24, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 M 2X F 1922 Washington, DC 86 578-46-1698 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Maryland | Calvert Saint Leonard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20685 USA 1321 Flag Harbor Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. Black, White, etc. 1 ☐ Yes 2★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify White Specify 3 ₩idowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th Sales Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Palla James Corbitt McClure 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5728 Calvert Blvd, Saint Leonard, MD 20685 <u> Hardy Sorrell - Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 2/8/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kenal Failure cutous ive Due to (or as e consequence of) desteus ion quentially list conditions Due to (or as a consequence of) Aton COVERDA

Physician /Medical **Examiner**

physician and s tha burial-trans

Department of Health Important: If item 27 any Injury or other tr once.

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show up or other thaumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Physician/Medical ģ Completed Be 2 Certification:

To the Hospital or Attending Physician: The law requires that the death certificate be executed

this

after death.

I Director: After the din by the funeral

within 24 hours a To the Funeral I

Division or Vital Records, P.O. Box 68760,

it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2€ No 27. Manner of Death 5 Pending investigation

15 Natural

2 Accident

3 Suicide

(Check only one)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

Due to (or as a consequence of)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of ceuse of death?

1 ☐ Yes 2 ☑ No

1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David J. Tardio, MD 110 Hospital Road, Ste 310, Prince Frederick, MD 20678

State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 1 2 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 09-2009 Smith :20 AM 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Georges Cheverly Prince George's community Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Tamaica 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219-43-8354 Days Hours 1 □ M 28 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Glendale Prince Georges 1) Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7201 GlenPine 20769 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1□Yes 21 No Specify: BIACK Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4or 5+) Domestic 6+h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charlie Douglas Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7201 Gienfine St Giendale, mp 20769 maria Reid gaugnter 20b. Place of Disposition (Name of cometery, crematory or other place)

Salem Presbyterian Cem. 02-21-2009 Jamaica W.I 20a. Method of Disposition 1- Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bianchi 814 uponur 3t NW Wash, DC 20011 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? mallitus 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No RESDIVETON 2 No

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other any injury or other treumatic event sone.

Physician

/Medical

Examiner

10a. State

Director

þ

Completed

MD

Funeral

Director

e filed within 72 hours after death with the Marylan at Hygiene other then context on 23a or 28a-1 ehow other then "netural", or items 23a or 28a-1 ehow vent, the Medical Examinat must be notified at

Baltimore, Maryland 21215-0036

Examiner been signed by the attending physicien and should be detached for use as the burial-transit

After this certificete funeral director, pag

Physician/Medical

Division of Vital Records, P.O. Box 68760, death.

Completed by Be Certification: To Medicai

The law requires that the death certificate be executed

within 24 hours after death To the Funeral Director: A completely filled in by the fi

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

P ₩atural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only one)

NZ Inpatient

28a. Date of Injury (Month, Day Year)

28c. Injury at Work?

racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

1 ☐ Yes 2 ☐ No

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date, signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reratay Murthy 6130 Landover RO

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature rack

State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** FEB. 26, 2009 CORA FLORENCE SHANNON 7:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ABBEY MANOR LA PLATA CHARLES 8. Date of Birth (Month, Day, Year) 7 – 1 2 – 1 9 2 2 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD • **Funeral** 1 □ M 2 □ Months Days Hours Min. 216-12-0339 86 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits id other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at LA PLATA Director MD. CHARLES 1 TWes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 WESLEY DRIVE 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2**X** No Maryland 21215-0036 1 ☐ Yes 2 ☐ No ₽ A Specify Specify: WHITE 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CHARLES CO. Elementary/Secondary (0-12) College (1-4or 5+) SCHOOL TEACHER BD. OF EDUC. 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) thand 2 should be file Health and Mental H tem 27 is marked oth Be HENRY J. BOWIE FLORENCE L. GILROY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH BERGER-EXECUTOR 12690 WELLINGTON BEACH RD. NANJEMOY, MD. 20662 : If item 2 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. TRINITY MEM.GARDEN 3-4-2009WALDORF, MD. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO0479 RAYMOND FUNERAL SERVICE, P.A. T.A PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complication, the taused the death. Do not enter the shock, or heart failure. List only one could one each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VAN CUE disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ signe be (1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Physician: The certificate 2 No 1 □Yes 2 XNo 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 1 ⊟ Yes 2 🖼 🕅 o Certification: To 1 | Inpatient 2 ER/Outpatient 3 DOA 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 24 hours after death. Funeral Director; A 2 Accident 2 □ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number cause of death (Item 23a) (Type, 30. Nante and address of pe 31. Date filed (Month, Day State Registrar

DX

			For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of rtificate of			giene Reg. No. 20	09 0691	8
	Physici /Medic		1. Decedent's Neme (First, Middle, HENRY 67	()	IPSON			2. Date of Dea		3. Time of Death	
1	Examin	er	4a. Facility Name (If not institution,			4b. City, Town,	or Location of De	eath	4c. County		
- 25			Mandrin Chesapea			Harwood		re la Bata (B)		rundel	
	Funeral Director		5. Social Security Number 078-12-9982 Usual Residence of Decedent	. Sex 1 M 2 □ F 86	e (In yrs. last birthday) Yrs.	Months Days		Irs. 8. Date of Birt in. (Month, Da Dec. 9	, Year) , 1922	9. Birthplace (State or Fore Country) New York	ugn
	land		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Lim	its
	Mary -f sh	ţo	Maryland Anne Ar	undel	Churchton	1				1 ☐ Yes 2 1	No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?	
	th with	alD	1119 Harbor Way			20733	3		USA		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any Injury or other traumetic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 MYes 2 □ If Yes, Give Year or Dates:	Novertien	Was Decedent of If Yes, specify Cu 1 □Yes 2ÃNo		(Specify Yes or No erto Rican, etc.)		e - American Indian, kk, White, etc. :: White	
5-0	72 ho	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occ	upation e during most of s	vorkina	16b. Kind of Bu	siness/Industry	
2	ithin Jan "e.	Completed	Elementary/Secondary (0-12)	3 College (1-4or	5+) Magta	DO NOT use retir Sergea:	e during most of v red)	rorking	IIO A I		
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and	be fill	Be	17. Father's Name (First, Middle, La Walter F. Thom	,			_ 11000	lame (First, Middle,	Maiden Surnam	e)	
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Ma	d 2 sl th an 7 is r traur		19a. Informant's Name/Relationshi					Rural Route Number chton, MD.		State, Zip Code)	
	1 and 2 Health (tem 27 is		20a. Method of Disposition		20b. Place of Disponentery, cre			Date Date		City or Town, State	
no.	Pages nent of hant of hant. If Ite		1 ☐ Burial 2 ☐ Cremation 3				i .			•	
altimore,	permit. Page Department of Importent: If any Injury or once.		4 □ Donation 5 □ Other (Special Service Li		Kalas Cre	ematory 2. Name and Add	i2/1	6/2009	Edgewate	er, Maryland ineral Home	_
Ba	Department Department Important In any Ir		March 11	slas &	20	973 Solor	mons Isl	eorge r. and Rd E	daewater daewater	neral Home ,Maryland	
			23a. Part 1. Enter the disease, or c	omplications that cause	d the death. Do not en					Approximate	
	Physician		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each I	ne. Oh	1 Drie 1	habut	- Pulmoz	em ch	Interval Between Onset and Death	,
-	/Medical		disease or condition resulting in death)	Pa. Due to (or as	a consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	py 7 200	- 7	40 9 10	7000000	_
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):						
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89		edic		u							
.O. Box	The law requires that the death certificate has been signed by the attending its agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown		2 Fetal death 3	☐ Ectopic pregna ☐ Other (specify)			23d. Dat Mo	te of delivery Inth Day Year	
۳.	that ned b		Part II. Other significant condition	s contributing to death I	out not resulting in the u	nderlying cause o	given in Part I.	23e. Did to	obacco use conti	ribute to the cause of death?	
Records,	quires t n signe ald be o	d by						_ les	res 2 □ No	3 Probably 4 ☐ Unkno	wn
00	w requir s been s should	Completed						24a. Was	an 24b. \	Were autopsy findings availa	ble
Re	: The law cate has I	Ę.							rmed?	orior to completion of cause of death?	of
Vital	sician: The certificate rector, pag		25. Was case referred to medical				26 Place of I	1 ☐ Yes Death (Check only o		1 ☐ Yes 2 ☐ No	
>	9 8	o Be	examiner? 1 ☐ Yes 2 🔊 No	Hospital: 1 ☐ Inpat	ent 2 ER/Outpatie	nt 3 DOA	thor:	g Home 5 Resid	M	er (Specify) HOSPICE	
οl	g Phys ter this neral dir	n:T	27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Time o				now injury occurr		- -
0	ath. ath. ir: After ne funera	atio	1 Natural 5 Pending 2 Accident investiga	tion	ay, reary injury		Yes 2 No			()0-(
Division	the Hospitel or Attending hin 24 hours after death. the Funerel Director: After apletely filled in by the funer	Certification: To	3 Suicide 6 Could no 4 Homicide determin	ad 28e. Flace of in	jury - At home, farm, st c. (Specity)	reet, factory, office	е	28f. Location (S City or Tox		er or Rural Route Number,	_
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	To the Hospitel or A within 24 hours after or To the Funerel Direct completely filled in by	ical	(Check only 2 ■ Medical E	Physician: To the best xaminer: On the basis	of examination and/or i	th occurred at the ovestigation, in m	time, date and pl y opinion, death o	ace, and due to the ccurred at the time,	cause(s) and made date and place, a	anner as stated. and due to the cause(s)	
	the l	Medical	One)	and manner s	tated.	200 Lino	ngo numbor		Old Data sinas	d (Adamete Day, Mars)	
	2		29b. Signature and title of certifier	AY A	a ly	290. Lice	nse number	138		d (Month, Day, Year)	
			7000	A Sw	7		V (1 - 0	Just	ary 16,00	_
	MW		39. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print	USE HA	HWAY A	NNAPOU	MD21401	
	Sta	ite	31. Date filed (Month Day, Year)	2. Regist	rar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 Ethel May Toms 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner 8128 Pete Wiles Rd. Middletown Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 05/23/1928 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** √A Aintry, Days Hours 1 ☐ M 2 🔀 F Months 219-20-3976 80 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Exacilmen must be notified at MD Frederick Middletown 1 ☐ Yes 2 No Director 28a-f 2 should be filed within 72 hours after death with the N nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8128 Pete Wiles Rd. 21769 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 X Married 1 ☐ Yes X☐ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) store cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Vivian K. Fawley Gladys Tritapoe ഉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Gary Toms (Husband) 8128 Pete Wiles Rd., Middletown, MD 21769 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Xedrial 2 Cremation 3 Removal from State 02/17.2009Lovettsville, VA Union Cemetery on 5 ☐ Other (4 Donation ecify) ²²Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell CERVIX - Signet **Physician** ANCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-trans and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 mont Month Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐Yes 2 ☐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide

P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

completely

Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month-Day Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Brunwick, MD 21716

22037

AUC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Kihland

32. Registrar's Signature

DHMH 17 Rev 1/2001

3altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		for State	State of Maryland				lental Hyg	iene 2000	06921
		Registrar 1. Decedent's Name (First, Middle, Last)		Certii	ficate of L	Jeath	2. Date of Deat	eg. No.	2 Time of Dooth
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Exami		4a. Facility Name (If not institution, give s	1 1 /	41	b. City, Town, or	Location of Death	,	4c. County of Deat	Mica
Funeral		5. Social Security Number 6. Sex	1		Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birt	hplace (State or Foreign
Director	1	196 - 28-1224 14 Usual Residence of Decedent	M 2□ F 72	Yrs.	Days	Hours Will.	03/13/	36	PAI
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ne Mar 8a-fsl	Director	VA ACCOM	ACK Ch	inco	7 TeA 10f. Zip Code	gue			1 ⊠Yes 2 □ No
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death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was	s Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	erican Indian,
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an y rail of a let with and Mental Hygiene and Mental Hygiene is marked other than aumatic event, in a let a	Be	17. Father's Name (First, Middle, Last)	21.			18. Mother's Name			
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3 60		20a. Method of Disposition 1 Burial 2 X Cremation 3 R	20b. Plac		on (Name of ory or other place	e)	Date	20c. Location - City or	CO., PA 23336 Town/State
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permit. Departrimports any inju		21. Signature of Funeral Service License	₽ .	Fo	lame and Addres	14015TO	NFI	HRO Chix	Icc. V# 23336
		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. e cause on each line.	Do not mer t	the most of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Capy.	tema					6 y/)
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cate be executed physician and the burial-transit	dical		l						
	/Mec	IF FEMALE:	3c. If yes, outcome of pregnance	:V				22d Date of del	Brown
death death e atter	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 🗆 E	ctopic pregnancy ther <i>(sp</i> ec <i>ify)</i>	/		23d. Date of del Month	Day Year
that the dended by the a	Phys	9 ☐ Unknown Part II. Other significant conditions cor	9 Unknown	ng in the unde	rtvina ozupo aive	on in Port I	1 23e Did toh	pacco-use contribute to	the cause of death?
w requires that s been signed!	ted by	Tarkin Other organicant conditions con	and the first results		mying dadoc give		1- Ye		robably 4 Unknown
0 a 0	Completed						24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of
vitali sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Death	1 🗓 🗸 2		2 □No
Physic this ca	ြု	1 Yes 2 No		R/Outpatient		4 LI Nursing Ho		nce 6 Other (Spe	ecify)
ding Phy th. After thi funeral o	tion	27. Manner eath 1 1 latural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	8b. Time of Injury	28c. Injury Work	yat (? Yes 2 ∐No	28d. Describe ho	w injury occurred	
or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street	, factory, office		28f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C		sician: To the best of my knowl ner: On the basis of examination and manner stated.						
To the within To the comple	Mec	29b. Signature and title of certifier	and manner states.		29c. License	e number	2	9d. Date signed (Mont	h, Day, Year)
6.1		120			Ita	05691		2/17/09	
DAN		30. Name and address of person who co	der ra	5 E	nt) Carr	(1 st s	SALULY	MS Z	180/
S [.] Regis	tate trar	31. Date filed (Month, Day, Year) FEB 17 2	32. Registrar's Signatur	b. So	and .				

			For State Registrar	State of M	arylan		artment <i>rtificate</i>			and M			e .200	9	06922
	Physici /Medic		1. Decedent's Name (First, Middle Eke Ukej								2. Date of De Februar	ath			3. Time of Death 2:46P. M
1	Examin		4a. Facility Name (If not institution Holy Cross Hos)			l1ve	r Spr	ing			c. County of I	ome	
	Funeral Director		5. Social Security Number none	6. Sex 7. Ag	ge (In yrs. 71	la <i>st birthd</i> ay) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir June 15	1 th 1 ^y 2	57 N		place (State or Foreign ofry) Pria
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State Maryland 10b. County Montgo		10c. City, Town or Location Silver Spring									1	0d. Inside City Limits
	th with the 23a or 28a	al Direc	10e. Street and Number 13003 English Turn	Drive			10f. Zip (20904			10g. Citizen of What Country? Nigeria			ntry?
980	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, it is midical Exaction in the incitified at	d by Funeral Director	11. Marital Status 1 Never Married 2 X Mar 3 Widowed 4 Divorced	I If Yes, Give)		Was Decede If Yes, specii 1 □ Yes 2	fy Cuba	ispanic Ori n, Mexican Specify:	igin? (Spo n, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, V Specify:		
Baltimore, Maryland 21215-0036	d within 72 ho giene. rr than "natu	Completed		t's Education st grade completed) College (1-4or t	5+)	16a. Dece (Give life. Profes	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) SSOr						Kind of Busin		dustry
yland	ould be filed Mental Hy, larked othe latic event,	To Be C	William Ukeje William Ukeje Uwere Ukeje												
e, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It is in deal Event in consists in this data once.		Nnenna Okigbo 20a. Method of Disposition		20h P	1300.	3 Engl	ish	Turn	Dri		ver		, 1	1d. 20904
Itimor			1 Burial 2 Cremation 4 Donation 5 Other (S	lace of Dispo emetery, crei eje Fai	mily C	Comp	ound	2/23		Por	rt Hərc	oui	ct, Nigeria		
8760, 49	cate be executed Physician and Physician and Ithe burial-transit	dical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fram, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pul Due to (or as	monal a consequer Co	n. Do not enter y Embourne of): Dogulation of): Dogulation of): E Cance	olism	of dyin					ille, M	lary	71and 20705 Approximate Interval Between Onset and Death
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Feta	Ideath 3[☐ Ectopic pre☐ Other <i>(sp</i> e		1				23d. Date o Month	f deliv	ery Day Year
ords, P	w requires that the de s been signed by the a should be detached f	by	Part II. Other significant conditions Deep Venous Th	-	out not resi	ulting in the u	nderlying ca	use give	en in Part I.				37		ne cause of death?
al Rec	n: The law r icate has be r, page 2 sh	Completed									24a. Was autor perfo 1 □Yes		l prio	r to co th?	psy findings available mpletion of cause of 2 XNo
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir investi 2 Accident investi 3 Suicide 6 Could detern	Hospital: 1 Inpati 28a. Date of Inju ggation not be 28e. Place of Inju joed	ury ay, Year) jury - At ho	₹R/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work	er: 4 □ Nu	ursing Ho	me 5 Resi	dence how inj	ury occurred		iy) al Route Number,
á	To the Hospital or within 24 hours after to the Funeral Director Completely filled in the formal completely filled in the form		29a. Certifier 1 Certifyii	ng Physician: To the best	of my kno	wledge, deat						cause	(s) and mann		
	To the He Within 24 To the Fu completel	Medical	(Check only 2 Medical one) 29b. Signature and title of certifie	(())		tion and/or in	29c.		e number	IN OCCUM		29d, D	nd place, and ate signed (M	onth,	Day, Year)
, _	8		30. Name and address of person Thomas B. Rami	who completed cause of				bso	Silv	er S					

State Registrar

31. Date filed (Month, Day, Year) FEB 18 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 02 UONG **Physician** 0052 M \mathcal{W} 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6819 Megan Lane Greenbelt If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** M 2□F Months Days Hours Min Dec. 1939 69 220-04-7045 Vierram Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examinar must be notified at Greenbelt 1 Xes 2 No Maryland Prince George's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 United States 6819 Megan Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 14 Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: ASIAN þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural", Completed Department of Health and Mental Hygiene, Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-405 5+) Elementary/Secondary (0-12) Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname)
Tan T. Nguyen 17. Father's Name (First, Middle, Last) Be Quynh D. Vuong ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6819 Megan Lane Greenbelt, Maryland 20770 Hoa M. Ly -wife 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 2/16/2009 Alexandria, Virginia 4 Donation 5 Dother (Specify) Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licenser PA Maryland 20**7**05 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line, Approximate Interval Betweer Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** 00 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on. Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 HInknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 2 No 1 ☐ Yes 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation in 24 hours after death.

Refuneral Director: Af olderely filled in by the fur 1 ☐Yes 2 ☐No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely within 2 and manner stated the 29c. License number 29d, Date signed (Month, Day, Year) P

State Registrar Name and address of person

31. Date filed (Month, Day, Year) FEB 18

DHMH 17 Rev 1/2001

YENSE HIGHWAY

d cause of death (Item 23a) (Type

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#16aperINF, 2/24/09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day P M IRENE VOGEL February 12, 2009 7:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 X F Yrs. 578-44-1841 73 Jan. 12, 1936 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 🛛 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 United States 9624 Annlee Terrace Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify Specify. 3 N Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychologist 5+ Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kuzminsky Nettie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Vogel, 10016 Avenel Farm Drive, Potomac, MD 20854 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogration 5 ☐ Other (Specify) Mt. Lebanon Cemetery 2/15/2009 Adelphi, Maryland 22. Name and Address of FacilityHines-Rinaldi Funeral Home, Inc. 21. Sign fure of Funeral Purvice I 11800 New Hampshire Avenue, Silver Spring, MD 20904 23a. Part¹. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARREST 10 minutes Due to (or as a consequence of): CORONARY ARTERY DISEASE 10 years Dust to (or as a oursequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown

Physician /Medical Examiner

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Physician

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event, the Medical Examiner must be notified at

"natural", or items 23a

if Health and Mental Hygiene. item 27 is marked other than other traumatic event, in the Mean other traumatic event, in the Mean item.

permit. Pages 1 Department of H Important: If ite any Injury or ot

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine attending physician for use as the buria Physician/Medical signed b Completed Be မှ Certification: s after death.

I Director: A
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disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a 2

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

29c. License number MD18126

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

1 ☐ Yes

2 🗆 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry B. Fox, M.D., 2440 M Street, NW #606 Washington, Dc

31. Date filed (Month, Day, Year) FEB 17

29b. Signature and title of certifier

29a, Certifier

37 Registrar's Signature

		•	For State Registrar	State	of Marylan		artment of rtificate o		and Menta	al Hygie	2009	06925
,	7	n.	1. Decedent's Name (First, Middl	e, Last)						te of Death	Day Year	3. Time of Death
100	Physici /Medio	_	Eva Maria Va	nGorkum							17 2009	3:00P M
	Examir		4a. Facility Name (If not institution	n, give street and ni	umber)		4b. City, Town	, or Location	of Death		4c. County of Death	1
-	×.	\ .	Frostburg Vi				Fr If Under 1 Yea	sotbur		Allega		
	Funeral		5. Social Security Number 078–28–1760	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 85	Yrs.	Months Day		Min. (Mo	te of Birth onth, Day, Ye	ear) Co	nplace (State or Foreign untry)
M _a	Director		Usual Residence of Decedent	L	05				Dec	. 23,1	.923 Ger	many
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Mar B-f s	tor	WV Mi	neral		Key	ser					1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number				10f. Zip Code	Э		10g	. Citizen of What Co	untry?
	23a	al	HC 72, Box					6726			USA	
	ar des	Funeral	11. Marital Status	Armed F		.S. 13.	Was Decedent o If Yes, specify Ci	f Hispanic Or uban, Mexica	igin? (Specify Ye n, Puerto Rican,	etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Mar 3 🕅 Widowed 4 ☐ Divorced	If Yes G	2 📉 No live		1□Yes 2XIN	lo Specify.	;		Specify: W	hite
21215-0036	172 hours after death with the Maryland "nstural", or itsma 23e or 28e-f show idical Examinat must be modified at	edt	15. Deceder	nt's Education		16a. Dece	dent's Usual Occ	cupation		16	b. Kind of Business/l	
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212	d within giene. or then	mo;	12	Collage	(1-401 5+)	Hor	nemaker				Own H	ome
pu	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 is marked other than other traumatic svent, tra Me	Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name (First,	Middle, Ma.	iden Sumame)	
/lai	should be ind Mental marked o	ပို	Gustav Sch	ulze		,		I	uise Le:	istner	·	
Maryland	and and is my	r II	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Stre	et and Numb	er or Rural Route	e Number, C	ity or Town, State, Z	lip Code)
	1 and Health Iem 27 other tr		Janet Cunningh	am/POA	20h 5		72, Box	240	Keyser,		26726	Form Clate
Baltimore,	m O .		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation	3 □Removal from		cemetery, cre	sition (Name of matory or other p	olace)	Feb.		c. Location - City or	Iown, State
ij	permit. Page Depertment of Important: If sny injury or poce.		4 Donation 5 Other (5		Po		Memorial		ns 2009		Keyser,	WV
Bai	Deperminent of the population		21. Signature of Funeral Service	Licensee	111	2	2. Name and Add		SHITCH		al Home	
	40.2 * 4		23a, Part 1, Enter the disease, o	r complications that	caused the deat	th. Do not en	85 S. M					726 Approximate
E	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	each line.	d 81		-	nentia Disea			Interval Between Onset and Death
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94	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	o (or as a consec	uence of):	- June 11	wys	NUCC	WE		J Jenrs
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ó	exec an an rial-tr	Exa	resulting in death) Last	Due to	(or as a consec	uence of):						
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9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:									
Вох	death certifica attending ph d for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregna birth 2 Peta	al death 3	□Ectopic pregna	ncy			23d. Date of deli	very Day Year
	the all	/s c	1 ☐ Yes 2 No 9 ☐ Unknown	4□Preg 9□Unk	inant at time of one of the community of	ieath 5[Other (specify)					
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Records,	has has	Completed	1.01	1 1 -00 9.	rolem	m,				autopsy performe	prior to d	topsy findings available completion of cause of
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of	Phy or this oral d	1: To	27. Manner of Death	28a. Date	e of Injury	28b. Time o	f 28c. Ir	njury at			injury occurred	,ar y)
ion	th. Th.: Afte	atlo	1 Natural 5 Pendi 2 Accident invest	ng (Mo igation	nth, Day Year)	Infury		Vonk? □Yes 2□]No			
Division	Atta	iffe	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 289. Place	e of Injury - At h		reet, factory, offic	СӨ		cation (Streety or Town, S	et and Number or Ru State)	ıral Route Number,
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	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Check only 2 Medicel	Examiner: On the	ne best of my kno basis of examina nner stated.	owledge, deal ation and/or in	h occurred at the vestigation, in m	e time, date a y opinion, de	nd place, and du ath occurred at th	e to the caus he time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certific	er C./ (11		29c. Lice	ense number	1.	29d	. Date signed (Month	n, Day, Year)
	-			2 (4	andly	~ Hh		144	-64		02/24/	2007
			30. Name and address of person	who completed car	use of death (Iter	m 23a) (Type,	Print)				•	
			S.L. Sandhi		48 Tarr		ce Fri	stburg	, MD 2	21532		
3	Sta		31. Date filed (Month, Day, Year		Registrar's Signa			14				
	Regist	rar	WAR	0 4 2009	Phones	1.	Mark					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 12, 2009 Physician 5:57P. L. WEAVER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 1707 E. Bancroft Lane Crofton 8. Date of Birth (Month, Day, Year) Sept. 20, 1916 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days North Carolina Months 1 ☐ M 2 【XF 92 578~05~4617 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Western Experies or must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Crofton Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21114 1707 E. Bancroft Lane Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after or the Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No White altimore, Maryland 21215-0036 Specify. ≥ 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Assistant Manager Giant Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William McCoy Manerva Carpenter Warlick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13215 Ronehill Drive Beltsville, Maryland 20705 William E. Weaver -son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of the Important: If ite any injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 2/16/2009 Brentwood, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA Lla 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 days Immediate Cause (Final Brain Hemorrhage **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ensiry to cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 XNo certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA မှ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner stated. (Check only one)

2

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day

FEB

18

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Esna-Ashari, M.D. 22 South Greene Street Baltimore, Maryland 21201 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

February 13, 2009

			For State Registrar	State of Ma	ryland /	•	artment of rtificate of					2009	3 0	6927
	Physici	an	1. Decedent's Name (First, Middle, Last	,						2. Date of De Month Februa		Yea	r	ime of Death
1	/Medic	al	Robert F 4a. Facility Name (If not institution, give			-	4b. City, Town,	or Location		Februa		3, 200 County of De		:20 A M
	Examin	ier	Anne Arundel Medi		r			napoli				ne Aru		,
	Funeral		Social Security Number 6. Se	x 7. Age	e (In yrs. last		If Under 1 Year Months Days	If Under	24 Hrs.	8. Date of Bir (Month, Da	th ay, Year)	9. B		State or Foreign
	Director		379-16-5489	ДM 2□F	87	Yrs.	Incitato Bayo	110010		Jan.30	,192	2 Mi	chiga	ın
	land w		10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. In:	side City Limits
	a-f sh	cto	Maryland Anne Art	ındel			Annapo]	lis					1[∐Yes 2∏ No
	or 28	Dire	10e. Street and Number				10f. Zip Code					zen of What (
	72 hours after death with the Maryland natural", or items 23a or 28a-f show fieed Exarch we must be uxified at	Funeral Director	103 Summers Run	12. Was Decedent B	Ever in II S	13.1		L409	igin? (Spec			ed Sta		lian
(Q	r iter		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ N		.	Was Decedent of f Yes, specify Cu			Rican, etc.)		Black, Wh	nite, etc.	
03	iral", c	d by	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:	1946		1∐Yes 2¶XNo	Specify:				Specify:	Whit	ce
21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16	6a. Dece	dent's Usual Occu kind of work done DO NOT use retire	upation e during mos	st of working	g	16b. Ki	nd of Busines	ss/Industry	
212	filed within Hygiene.	m o	Elementary/Secondary (0-12)	College (1-4or 5	+)	me. i	Sales	cuj			A	dverti	sing	
b	be filed ntal Hyg ed other event,	Be C	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle				
ylaı	should band Ment sud Ment	2	George Arthu		ŧ							Inerne		
Maryland	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (7)		ľ		ng Address (Stree						e, Zip Code)
	s 1 and f Health tem 27 other to		Nancy Welch Almgre	en/ Daugnte			sition (Name of natory or other pl			ate		1409 cation - City o	or Town, S	tate
m 0	Page:		1 ☐ Burial 2 🎇 Cremation 3 🗍 I 4 ☐ Donation 5 ☐ Other (Specify,		1		e Cremato		2/15/	09	Balt	imore,	Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Practic Lexic is at unat the practic any Injury or other traumatic event, the Practic Lexic is at unat the practic any Injury or other traumatic event, the Practic Lexic is at unat the practic at the practic and the		21. Signature of Funeral Service Licens	" Litt		22	2. Name and Add	ress of Facili	^{ty} John	M. Ta	ylor	Funer	al Ho	ome, Inc.
6			23a. Part 1. Ehrer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											oximate val Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. C C	PD								Onse	et and Death
4	/Medical Examiner		resulting in deality	Due to (or as	a consequenc	ce of):								
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe or injury											
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8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as	a consequenc	e of):								
687	ficate physi s the k	Physician/Medical		d										
Box (leath certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7=					23d. Date of o	delivery	
	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnar ☐ Other (specify)	ncy				Month	Day	Year
P.0	that the de ned by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions co		ut not reculting	g in the u	nderlying cause o	ivon in Part I		23e Did 1	tobaccou	ise contribute	to the cau	se of death?
ds,	w requires that s been signed to should be deta	d by	Takin Stroi Signinoun Conditions So	minuting to document	at not resulting	g in the u	ndenying dadde g	iven in r arci	•	1 🕱				4 Unknown
000	law req as beel 2 shou	lete								24a. Was	an	24b. Were	autopsy fir	ndings available
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/ita	cian: ertific	Be C	25. Was case referred to medical examiner?						e of Death	(Check only				10
of	g: 5		1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Departie	1 Lingpatient 2 LER/Outpatient 3 LI DOA 4 LI Nursing Ho					Home 5 ☐ Residence 6 ☐ Other (Specify)				
on	ding th. After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, Year)	Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No			28d. Describe how injury occurred				
Division of Vital Records,	Attendi	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ury - At home, (Specify)	, farm, str	eet, factory, office		2	8f. Location (Street an	d Number or	Rural Rou	te Number,
Ö	ital or Irs aft ral Dii	Cer												
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Tertifying Phy (Check only one) 2 Medical Exam	ysician: To the best liner: On the basis o and manner sta	f examination	dge, deat and/or ir	h occurred at the vestigation, in my	time, date a opinion, de	nd place, a ath occurre	and due to the ed at the time,	cause(s date and) and manner I place, and d	as stated. lue to the c	ause(s)
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C	1121		30. Name and address of person who c			a) (Type,	Print)	1	1	/			Mal.	
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		4	For State	State of	Maryland						-	-	0000	000	220
			Registrar 1. Decedent's Name (First, Middle	(act)	Certificate of Death Reg. No. 2009 05928 2. Date of Death 3. Time of Death								J Z O		
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- 1	Funeral Director		5. Social Security Number 220–28–6606	6. Sex 1 □ M 2 □ X F	7. Age <i>(In yrs. I</i> : 80	a <i>st birtnday)</i> Yrs.		Days	Hours	Min.	July 1	7 Year	9. Birti Co 1928 Mis	nplace (State or untry) SOUL1	roreign
			Usual Residence of Decedent												. I insite
	arylan show		10a. State 10b. County			, Town or Lo								10d. Inside City	
	he Ma	ecto	MD Anne A	rundel	Dav	ridsonv	7ille 10f. Zip C	chde.				10a. C	itizen of What Co		
	with t		10e. Street and Number 3511 Russell Th	omac Tano			101. 2100	, ouc	210	35			USA		
	death ms 23	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.S	S. 13.	Was Decede	nt of Hi			cify Yes or No Rican, etc.)		14. Race - Ame		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed For ed 1 □Yes If Yes, Giv Year or Da	2 Mo ∕e		ir ves, specil 1 □ Yes 2		Specify		nicari, etc.)		Black, White Specify: Wh		
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and	i be fil ntal H ed otl	m	17. Father's Name (First, Middle, I ROY D. FOYE	*					,		Simmon	,	ir Garriame)		
ΙŽ	should nd Me mark matic	<u>٩</u>	19a, Informant's Name/Relationsh			19b. Maili	ng Address (Street a					or Town, State, 2	Zip Code)	
	nd 2 s alth ar 27 is r trau		James D. Wolfe		on	351	11 Rus	sell	l Tho	mas I	Lane	Dav	idsonvil	le, MD	35
altimore,	es 1 a of Hea		20a. Method of Disposition	2 Dame of from 6	20b. P	lace of Dispo	osition (Name matory or oth	e of er place	e)	D	ate	20c.	Location - City or	Town, State	
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Balt	permit. Pages 1 Department of I Important: If ite any injury or of		21. Signature of Funeral Service I	licep oes		Į.	2. Name and						l Home		
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	Physician / /Medical		disease or condition resulting in death)	a	eumonia (or as a consequ	uence of):									
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687	tificate g phy as the	edic		u											
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1928 S, P.O.	that the de ned by the detached		Part II. Other significant condition	ons contributing to de	eath but not resi	ulting in the u	ınderlying caı	use give	en in Part	l.	23e. Did	tobacco	use contribute to	the cause of de	eath?
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ر ۾	The I	E O									perf 1 □ Yes	ormed?	death?	2 □ No	
₹ III	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?	10				l Out-		e of Death	(Check only	one)			
of V	ding Physician: The I h. After this certificate he funeral director, page		1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 🗆 28a. Date	Inpatient 2	ER/Outpatie			4 (2)		me 5 🗆 Res 28d. Describe		6 ☐ Other (Spe	cify)	
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Ife, Ma	l or Attending after death. Director: After	ifica	3 Suicide 6 Could a 4 Homicide determ	not be 28e. Place	of Injury - At ho	ome, farm, st	reet, factory,	office			28f. Location City or To	(Street	and Number or Ri	ural Route Numi	ber,
offe Divis	tal or s afte al Dire	Certification: To	4 Horricide	Dulla											
3	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check only one) (Check only one) 1 Certifyir 2 Medical	ig Physician: To the Examiner: On the band man	e best of my kno easis of examina ner stated.	owledge, dea ation and/or i	th occurred a nvestigation,	at the tir in my o	me, date a opinion, de	and place, eath occur	and due to the red at the time	e cause e, date a	e(s) and manner a and place, and due	s stated. e to the cause(s)	
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			> Andeeu	flear	del	W14)	. D0	036	716			2/	12/2009		
	1924	٢	30. Name and address of person								-				
	100		Andrew Kundrat 31. Date filed (Month, Day, Year)		110 Grac Registrar's Signa		d Rd.,	Si.	lver	Spri	ng, MD	209	04		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06929 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12, **GEORGE** WILLIAMS FEB. 2009 9:52 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F Hours Director 72 219-96-1969 20, 1936 **GRENADA** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner is ust be notified at once. 1 TyYes 2 □ No Directo MD. PRINCE GEORGES BERWYN HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6112 QUEBEC PL. 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: Completed by Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PARTS DISTRIBUTOR A&R AUTO PARTS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK. WINNIFRED WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BERYL S. NICHOLSON/WIFE 6112 QUEBEC PL., BERWYN_HEIGHTS, MD. 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 2-19-2009 RIVERDALE, MD. 21. Signature of Funeral Service Libensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed its certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe After this certificate 2 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**)** No 1 npatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STHI 3415 LION 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2009

Registrar

			For State Registrar	State of Ma	aryiana / i	Depan <i>Certi</i>	ficate of L	eaim and iv Death		Seg. No.	.009	06	730
			Decedent's Name (First, Middle, I	ast)					2. Date of Dea	ath	Vees	3. Time of	Death
	Physicia /Medic		Marion	Ε.	Walte	er			Feb. 13	, 20	009 Year	2:25	Р м
	Examin	_	4a. Facility Name (If not institution, g	ive street and number)		4		Location of Death		4c. Co	ounty of Death	1	
			Potomac Valley				Rockv				ntgomer		
	Funeral			Sex 7. Age	e (In yrs. last bii 91	1111001	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 2	n /, Yea <i>r)</i> 7 101	9. Birth	nplace (State o	
	Director		184-12-3160 Usual Residence of Decedent		91	110.			March 2	/,191	1/ Penr	sylvan	ia
	land ow		10a. State 10b. County		10c. City, Tow	vn or Locat	tion					10d. Inside Ci	ty Limits
	Mary Ff sh fied a	to	Md. Monts	gomery	Rock	ville	9					1 ☑ Yes	2 No
	r 28a	Director	10e. Street and Number		L		10f. Zip Code			10g. Citize	n of What Co	untry?	
	th wit 23a o ist be	a	1235 Potomac Va	alley Road			20850			U.S.	.A.		
	ems er m	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Wa	s Decedent of Hi es, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	 Race - Amer Black, White 		
98	or it		1 Never Married 2 Married	If Yes, Give	40	10]Yes 2█∏No	Specify:		s	Specify: Wh	ite	
Ö	72 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a	Deceder	nt's Usual Occup	ation		16b. Kind	d of Business/I	ndustry	
1 5	in 72 "na" r ledic	Completed	(Specify only highest	rade completed)		(Give kir	nd of work done of NOT use retired	during most of work	ding			,	
212	within jiene.	E	Elementary/Secondary (0-12)	College (1-4or 5	1+)	Secr	etary			Unit	ed Min	e Worke	ers
b	be filed within 72 hc tal Hygiene. d other than "natul event, the Medical	BeC	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	e (First, Middle,	Maiden Si	urname)		
/lar		일	John James Mate	s				Pearl F	rances	Higgi	.ns		
Maryland 21215-0036	and sand		19a. Informant's Name/Relationship		198	b. Mailing	Address (Street	and Number or Rui	ral Route Numbe #B2K	er, City or T	Town, State, Z	(ip Code)	
≥, ≤	≥ = N =		M. Susan Sacirbe	y/Daughter	Sì	taten	Island	Landing New Yor	k 1030			- 0: 1	
ore	S + = 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	cemete	ery, crema	ion (Name of tory or other plac	e) Febr	uary 16		ation - City or	_	
Ë	nit. Par artmen ortant: Injury		4 □ Donation 5 □ Other (Spe	**	Gate		eaven Ce				er Spri	ng, Md	
Baltimore,	permit. Page Department of Important: if any Injury or once.		21. Signature of Fyndral Service Lie	Col				ss of Facility De onsin Ave				20007	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that caused	I the death. Do						., D.C		
			shock, or heart failure. List or Immediate Cause (Final						, ,			Approximat Interval Bet Onset and	
	Physician /Medical		disease or condition resulting in death)	- u	ive Hea		'ailure					7 year	rs
	Examiner			Dysphag								7 year	cs
	a	ē	Sequentially list conditions, If any hauting to immediate cause. Enter Underlying Cause (Disease or injury	D	а consequence	of):							
R	cuted nd ransit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Ç	roidism							7 year	rs
0,	e exe ian al urial-t		resulting in death) Last	`	a consequence	e of):						7	
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical		d. Depress	51011							7 year	cs
9 x	certific ding p		IF FEMALE:	23c. If yes, outcome	of pregnancy					22	Rd. Date of dol	ivon	
Вох	eath certifi attending I for use as	ian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnant at	2 ☐ Fetal deat		ctopic pregnancy Other (specify)	1		23	Bd. Date of deli Month		Year
P.O.	that the de ned by the a detached i	Physician/M	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐Unknown			11101 (442,510)						
σ.	es that igned by		Part II. Other significant condition	s contributing to death b	ut not resulting	in the und	erlying cause giv	en in Part I.	23e. Did to	obacco use	e contribute to	the cause of	death?
ğ	w requires been sign should be	ed by	Dysphagia - inc	reased sym	ptoms				1□`	Yes 2∑	No 3□Pr	obably 4 🗍	Unknown
or Vital Records,	aw requisible been 2 should	Completed	Decreased appea	ite/anorex	ia				24a. Was		24b. Were au	topsy findings	available
A.	The I	E	generalized debility							autopsy performed? death? 1⊠ Yes 2□No 1□Yes 2☒No			
ita	sician: The law s certificate has b irector, page 2 s	Be C	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	ne)			
Ž	Physician: r this certifica ral director, i	户	1 ☐ Yes 2 2X No		ent 2 ER/O		3□ DOA Oth	4 W Nursing H	ome 5 Resid			cify)	
	Jing P		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		. Time of Injury	28c. Injur Wor M 1 □		28d. Describe I	now injury	occurred		
Sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	be 280 Place of ini	un/ - At home f	farm stree		Yes 2□No	28f. Location (S	Street and	Number or Ri	ural Route Nun	nhor
Division	or A after (Direct	Certification:	4 ☐ Homicide determin	building, et	c. (Specify)	idini, siros	n, ractory, cindo		City or Tov	vn, State)	rearribor or ric	770777001077017	1001
-	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page			Physician: To the best									
	ne Ho 1 24 h ne Fui iletely	Medical	(Check only 2 Medical E	caminer: On the basis of and manner st		and/or inve	estigation, in my o	opinion, death occu	erred at the time,	date and p	place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	<i>i i</i>			29c. Licens				signed (Mont	-	
	12		1 / Muy	Humis	conf.	2	[[<]	13971		02/1	13/200	9	
	1		30. Name and address of person w										
			Mary Haynos, CRI	NP 10110 M	olecula rar's Signature	r Dr.	#201 R	ockville,	, MD 208	50			
	Sta Regist		31. Date filed (Month, Day, Year) FEB 17 2	009	ars signature	har	4						

		-	For State of Maryl 1 - State Registrar		artment of <i>rtificate o</i>			lental Hyg	giene Neg. No. 200	9 06931			
ė.	Physici		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ith Day Yea	3. Time of Death			
	/Medic			MOOD		!#:-		FEBRUARY	13, 2009				
4	Examin	er	4a. Facility Name (If not institution, give street and number) UNION HOSPITAL		4b. City, Town		on of Death		4c. County of Death CECIL				
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)		ar If Und	der 24 Hrs.	8. Date of Birth (Month, Day	9. E	Birthplace (State or Foreign Country)			
	Director		212-30-9258 1 ¹ XM 2□F 7	6 Yrs.	Willias	ys Hour	3 IVIII.	4/18/1		MD			
	and and the transfer of the tr		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or L	ocation					10d. Inside City Limits			
	Maryl I-f sho fied a	Funeral Director	DE NEW CASTLE	NEWARK						1 □Yes 2X No			
	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number 5 MICHIGAN STATE DRIVE		10f. Zip Cod 197				10g. Citizen of What UNITED				
	death	nera	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic	Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian,			
36	or Ite	by Fu	1 ☐ Never Married 2 ⚠ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Yes 2 X			, ,	Specify:				
2-0036	thours salex	ed b	15. Decedent's Education	16a. Dece	edent's Usual Oc	cupation			16b. Kind of Business/Industry				
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2121	ed wit ygiene rer th a	Completed		SALA	ARY SUPE					MANUFACTURING			
Maryland	eve eve	To Be	17. Father's Name (First, Middle, Last) THOMAS S. WOOD				JANE		Maiden Surname)				
ary	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Type. Print)	I					er, City or Town, State	e, Zip Code)			
	s 1 and of Health item 27 other tr		KATHARINE P. WOOD/WIFE 20a. Method of Disposition	5 MIC b. Place of Disp	CHIGAN S			Date	20c. Location - City	or Town State			
0	0 0		1 X Burial 2 □ Cremation 3 □ Removal from State	cemetery, cre	matory or other VETERAN	place) IS	1	/2009	BEAR, DE				
altimore,	permit. Pag Department Important: I any Injury o once.		21. Standard of Fundal Service Licensee	EMORIAL	22. Name and Ad	dress of Fa	TN FH						
<u>n</u>	50 E E 9	4	Mohne Ugeral	1	000 N D	UPONT	PKY N		LE, DE 19				
Н			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Provided Heart										
	Physician /Medical		disease or condition resulting in death) Due to or as a consequence of):										
	Examiner		Dome Xia										
7	P #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):									
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ဖ	tificate ig phy as the	ledic											
Box	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pr	Fetal death 3	□Ectopic pregna				23d. Date of Month	delivery Day Year			
0	The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of death 5	Other (specif)	/)				- 1,			
Ω.	that the de ned by the s detached t	y Ph	Part II. Other significant conditions contributing to death but no	obacco use contribute	contribute to the cause of death?								
Records,	w requires that been signed by should be det	ed by						1 🗆 \	☐ Yes 2☐ No 3☐ Probably 4 Lunknown				
ဝပ္ပ	has bee	plet						autop	ta. Was an autopsy findings availa prior to completion of cause of				
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Division or	l or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Check only one) (Check only one) Certifying Physician: To the best of my and manner stated.										
	To the within 2 To the complet	Med	29b. Signature) and fittle of certifier	14.	29c. Lic	cense numb	er		29d. Date signed (M	bnth, Day, Year)			
}	->-0		X ol -	V-C	7 0	005	564	49	2/19/	09			
	,		39 Name and address of person who completed cause of death	(Item 23a) (Type	e, Print)	, 1	d	- 1	On- 4	11/			
	10		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	W- 11	igh	Jt ?	Duite	302 E	1Ktan 120219			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 16 2:46 PM 2009 JAMES R. WOODALL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours Min 1**∑**M 2□F 60 222-32-4430 03/12/1948 DELAWARE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 TYes 2 □ No MARYLAND HARFORD ABINGDON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 UNITED STATES 3641 WOODSDALE ROAD, APT B Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Armed Folces. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: UNKNOWN 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BTACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) SELF EMPLOYED TRANSPORTATION DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DORIS E. CLARK HOLLAND WOODALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY WOODALL / WIFE 3641 WOODSDALE ROAD, APT B, ABINGDON, MARYLAND 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/19/09 4 □ Donation 5 □ Other (Specify) FERRIS & CO, INC WEST CHESTER, PA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE · disa Cett-Colomon MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive years disease or condition resulting in death) Due to (or / a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in underlying cause given in Part I 1 ☐ Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year! 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide

Examiner 68760, ed by the a

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/Medical

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Director

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be filed within 72 hours after on the Hygiene.

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page 2 s Director: within 24 hours at To the Funeral C

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4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 7 2009 FEBRUARY **Physician** LOUISE WILLIAMS 12:57 P M CLARA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner · CHEVERLY PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL 8. Date of Birth (Month, Day, JUNE 3 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1944 1 □ M 2 😾 F Months JAMAICA NONE 64 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Vesical Evantiner must be notified at 1 ☐ Yes 2 ☑ No Director KINGSTON 10 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code and 2 should be filed within 72 hours after death with t leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 2 83 MONTGOMERY AVENUE NONE JAMAICA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 14 Never Married 2 ☐ Married BLACK 1 □Yes 2 □ No Specify: If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th SALES REP PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNKNOWN ELSEDA ALLISON ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 2324 BRIGHTSEAT ROAD # 3 LANDOVER, MARYLAND 20785 EVERALDO MITCHELL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State MAR 4 2009 DAVECOT MEMORIAL ST CATHERINE, JAMAICA 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Fundal Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arrythmi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at its content of the cause of the

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

State Registrar

Medical

3 Pate filed (Month, Day

29b. Signature and title of certifler

CRIR

29a. Certifier

MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Anne Younkins February 22 2009 1550 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17823 Oak Ridge Drive Hagerstown Washington 8. Date of Birth (Month, Day, Year) Aug. 6, 1946 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 62 Máryland Director 219-46-3195 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, It a Moderal Examiner must be notified at 1 □Yes 2 TNo Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17823 Oak Ridge Drive USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic event, It's Mostle once. Elementary/Secondary (0-12) College (1-4or 5+) Finance Manager Wholesale Paper Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Luther Waters Wanda June Rohrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Younkins - Husband 17823 Oak Ridge Drive Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park Feb. 27, 2009 Hagerstown, Maryland OSDEP AND APPENDED HOME. P.A. 425 S. Conococheague St. Williamsaport, MD 21795 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Atheroscleratic Cardiovascular Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-fransit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) P.O. I 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 11 No 1 □ Yes 25. Was case referred to medical examine: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 No 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 02/23/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, MD 21740 3H-7 etam 8t State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

FEB 17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nysicia		- For State Cer	tificate of Death	Reg.	No. 2009 069
Examir	n/	Decedent's Name (First, Middle,Last)	211	2. Date of Death Month D March 3, 20	3. Time of Death
-xanın		Rodney 4a. Facility Name (if not institution, give street and number)	Allen 4b. City, Town, or Location of	of Death	4c. County of Death
	ı	4320 Clareway	Baltimore		
neral ector		5. Social Security Number 6. Sex 7. Age (in yrs. la 213-70-4045 1 Xm 2 F 52 5	Months Days Hours	8. Date of Birth (Min. 7-24-	NWDD(YYYY) 9. Birthplace (State or Foreign Country) MD
fut		Usual Residence of Decedent 10c. City, 10a. State 10b. County 10c. City,	Town or Location		10d. Inside City Limits
show ice.	٦	MD N/A Ba	ltimore		1 X Yes 2 No
items 23a or 28a-f show any ust be notified at once.	Dire	10e. Street and Number 4320 Clareway	10f. Zip Code 21213		Citizen of What Country? USA
声립	Funera	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	S. 13. Was Decedent of Hispanic Origin fres, specify Cuban, Mexican 1 Yes 2 No specify:	, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Black Specify:
h and Mental Hygiene 27 is mai ked other than "natural", matic event, the Medical Examiner	ρ A	Widowed 4 Divorced If Yes, Give Year or Dates 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give		6b. Kind of Business/Industry
n 'nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT	use retired)	D: b1 - 4
ene er tha	du	10th grade N/A	Disabled		Disabled
d oth		17. Father's Name (First, Middle, Last)		's Name (First, Middle, Ma	
Menta mar ko : even	o Be	William Allen 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Nun	llian Lockh	
27 is		Eugene Allen-Brother	1119 Darley	Baltimore	, MD 21218
Department of Health and Important: If item 27 is injury or other the last	Ì	20a. Method of Disposition 20b. F	Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
ant: L	1	4 Donation 5 Other Specify:	Zion Cemetery	3-9-2009	Lansdown, MD
apartu nport ijnry o	ļ	21. Signature of Funeral Service Licensee	22. Name and Address of Facilit	narch ba.	
	_	23a. Part I. Enter the disease, or complications that caused the death.	Do not enter the mode of oving Such as o	cth Avenue	Balto, MD 21202 t, shock, or heart Approximate Interval
ician dical		failure. List only one cause on each line.		, , , , , , , , , , , , , , , , , , , ,	Between Onset and Death
niner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiov Due to (or as a consequence or			
		Sequentially list conditions, b			
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	Ę	if any, leading to immediate cause. Enter Underlying Cause	f):		
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n and - transit	al Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	f):		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mar	yland /		irtment of l tificate of		Mental Hy	gien Reg. No	711119	06937
П	Physicia		1. Decedent's Name (First, Middle, La	Esther	ASHE				2. Date of De Month March	Da	009 Year	3. Time of Death 4:40 A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)				r Location of Dea			County of Death	11.10
. ple			Montgomery Gene				01 ne	0	10.0-1		Montgome	
	Funeral Director		160-10-7494	Sex 1□M 2X□F 7.Age	(In yrs. Jast b	Yrs.	Months Days	Hours Min		th ay, Year, 19	15 Penns	place (State or Foreign otry) Sylvania
3	and Sw		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Tov	vn or Loc	cation				1	0d. Inside City Limits
	Mary a-f sho	tor	Maryland Montgom	ery		Silv	er Sprir	ng				1 □Yes 2 No
4	or 28g	Direc	10e. Street and Number				10f. Zip Code			•	itizen of What Cour	,
	s 23a	eral	3330 N. Leisure				209		Danalfi Van an Na		ited Star	
0000	s I am La Siloulu be ineu within 72 hours arer beam with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. The Ziloulus of the Walterland Trans 23a or 28a-f show other traumatic event, the Madical Examination and be relified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	er in U.S.	- 1	vas Decedent of r i Yes, specify Cub ☐ Yes 2 🂢 No	Hispanic Origin? (an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.))-	14. Race - Americ Black, White, Specify: Wh	etc.
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7	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			oo not use retire maker	a)			Own Home	
ב ב	Mental Hygiene Mental Hygiene arked other thar atic event, the h	Be C	17. Father's Name (First, Middle, Las	t)	·				me (First, Middle	, Maider		
A da	snould band Ment s marked umatic e	2	Harry Cohen						(unknowi	<u> </u>		
Mar	alth and 27 is me 27 is me 27 is me er traume	1	19a. Informant's Name/Relationship Adela Shapiro,					and Number or A Court, Ro			or Town, State, Zip 20853	Code)
	ent of He ent of He nt: If item ny or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State			sition (Name of natory or other pla e Cemete		Date 18/09		ocation - City or To	
Dallillo	permin. Prages I and Z Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Juneral Service Lice			T0	Name and Addre	Hebrew 1 St., N	Funeral	Hom	e	20012
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the	e death. Do	not ente	er the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	OII, DC a	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	A (UH	2 mic	nSe	nteric	Ischen	uia		2 day	nset and Death
	/Medical xaminer		resulting in death)	Due to (or as a	consequence							
7	2 1 / =	iner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (unas a c	edinelipae rud	oty:						
-	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence	of).						
foot bo	physician and s the burial-transit	edical E		d								
00 1	ing ph	Medi	IF FEMALE:							- 1		
O. DOX	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Wo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal deat		Ectopic pregnand Other (specify)	ey			23d. Date of delive Month	ery Day Year
֓֞֞֜֞֜֜֞֜֜֜֜֜֜֜֓֓֓֓֜֜֜֜֜֜֓֓֓֓֓֓֜֜֜֜֜֓֓֓֓֓֜֜֜֜֜֜	gned b	by Ph	Part II. Other significant conditions	1 A	not resulting	in the un	derlying cause giv	ren in Part I.	23e. Did t	obacco	use contribute to the	ne cause of death?
cords,	sen sig	ted k	Gastrointestina	bleedin	J. 1	Cha	5domyo	19515	1 🗆	Yes 2	□ No 3□ Prob	oably Unknown
ביים ביים	certificate has been signed by the rector, page 2 should be detached	Completed	-							osy ormed?	prior to co death?	psy findings available mpletion of cause of
	ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of De	1 □ Yes ath (Check only o	one)	oj ilites	2 🗀 110
5	this or	္ရ	1 ☐ Yes 2 ☑ No		2 ER/O			4 🗆 Nursing i	T		6 ☐ Other (Specif	y)
5	th. After funer	tion	27. Manner of Death ↑ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, 1		Time of Injury	28c. Inju Wor M 1 🗆	ryat k? Yes 2 ∐ No	28d. Describe	how inju	ry occurred	
	within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not to determine determined	e 290 Place of Injury	At home, fa	arm, stre			28f. Location (nd Number or Rura e)	l Route Number,
ַ קַּ	urs aft eral Di		29a. Certifier 1 Certifying P	husisian. To the best of	mar les arries d'							
Hos	n 24 ho	edical		hysician: To the best of miner: On the basis of e and manner state	xamination a							
\$	Vithii Comp	Ň	29b. Signature and title of certifier	100			29c. Licens	se number	_	29d. Da	ate signed (Month,	Day, Year)
	15		20 Name and address of	P V V	th /lta== 00:	(Tim - 5	D (vint) a 2 2 2 2	0) 113		7 -	4-600	
	1/			ing, M	of the	Mype, F	18101 1 Geru	Prince P	n3 piral	'ive	, Olney,	MD 20832
	Sta Registra		31. Date filed (Month, Day, Year) NAR 0 6 2	32/Registrar	Signature	do	wes					

Registrar

State Registrar 29b. Signature and title

Hunten

31. Date filed (Month, Day, Year)

of certifier

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MAR 0 6 2009

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P.U DUX 1733 SACGBUY US

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** 02:00 PM Eugene Austin, Jr. Februar 28 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SINAI MOSPITAL RACTIMORIZ CITY BALTIMORE OF If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐xM 2 ☐ F Months Days Hours Min. Feb 21, 1936 Director Maryland 216-34-5587 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show traumatic event, the Medical Eval-free route by notified at Director 1 Yes 2 No **Baltimore Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö U.S.A. 23a 21207 6814 Brompton Road Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 195 Ye ar or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 2 Married 21215-0036 1958 natural", or 1 ☐ Yes 2 ☐ No Specify: 2 Black 3 Widowed 4 Divorced 1960 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Perkins State Hospital LPN 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental and 2 should be Emma M. Eden Eugene Austin ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra 6814 Brompton Road Baltimore, Maryland 21207 Jeanette Austin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 03/06/09 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death D of enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prevmoria **Physician** disease or condition resulting in death) Seek /Medical Due to (or as a consequence of) Examiner STAGE Kenal END Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury iner The law requires that the death certificate be executed Exami mellitus type 2 Dioubetes that initiated events resulting in death) Last burial-tra Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Por Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed need Stroke 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate obstructive 2 □No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ØNo 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Box 68760% Ö ۵. Records, of Vital Division

To the Hospital or Attending Physician: After thi funeral within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Medical 29b. Signature and title of certifie

27. Manner of Deat

1. Natural

2 Accident

4 Homicide

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

5 Pending investigation

6 ☐ Could not be

determined

State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM NEWPOND S. MAI HOSZLIAL OF BALTIMORA MBBS

32 Registrar's Signature MAR 0 6 2009

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES -000

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

telruar

2401 W Belvedore Avenue

29d. Date signed (Month, Day, Year)

28 2009

amend #19a Per FH G889 3/10/09 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ANTHONY DUANE ANDREWS **FEBRUARY** 28, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 330 Webster Street Harford 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months New York Director 095-28-9569 1932 76 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, The Modes Even in transite mother or 1 XYes 2 ☐ No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Webster Street 21014 USA Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 2 Specify. 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should hand Mer Anthony (nmn) Andrews Ruby Eloise Litch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s / Health *a* Emily V. Andrews / Wife 330 Webster Street, Bel Air, Maryland, 21014 permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Services Corp. 3-5-09 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op-each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events that initiated events are sufficient or the control of th Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit ONGESTIVE and resulting in death) Last Due to (or as a consequence of) Box 68760, physician s the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Duknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐Yes 2 No 2 No of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 □Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of/der 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DYFD 2222 MA 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registraramend 25,27 per Dr. g889 3/6/Ritificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day 2009 HNDERSON January 23 15:57 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months NONE 12009 Director Usual Residence of Decedent 10a, State 10b. County 10c City Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Expurient outher traumatic event, the Medical Director MD NOTTINGHAM TX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? MARJEFFI 21236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFAN7 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be HNDERSON 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greater Baltimore, MEd Ctr 6701 N. Charles Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State permit. 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 2 a. Part I. Enter the diseas , or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Pre maturity 22 Weeks gestation requires that the death certificate be executed sician and burial-trans resulting in death) Last Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) P.O. Auter uns certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vital 2 2 □ No 1 □Yes 1 TYes Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Hospital or Attending Division 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar bah

31. Date filed (Month, Day,

, 6,701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G-BMC, 6 32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Physician 28. 7:30 P M C Bowe Willie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton 9. Birthplace (State or Foreign Country) 1915 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min Hours 1 ☑ M 2 ☐ F 94 Director 24, Jan. 225-12-7381 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified a once. Director 1 ☐ Yes 2 ☒ No MD Prince George's Forestville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20747 USA 5704 East Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 ∑No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Essie Doxey ဂ Raymond N. Bowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 East Place, Forestville, Essie Matthews-Daughter MD20747 20b. Place of Disposition (Name of cemetery, crematory or other place)
Greenlawn Memorial
Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-9-09 Chesapeake, VA 22. Name and Address of Facility Corprew Funeral Home 21. Signatu of Funeral Service Licensee 1822 Portsmouth Blvd., Portsmouth, VA 23704 23 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ORONdr /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No detached f P.0. 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 certificate 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☑ No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BoTe m outhern Ave 21me 0 3 . Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	-	artment of F <i>rtificate of I</i>	lealth and N D <i>eath</i>		jiene _{eg. No.} 2 () (09 06943
			Decedent's Name (First, Middle, Last	t)					2. Date of Deat	th	3. Time of Death
	Physici		Elva H.	Bugey					Month	Day	2009 9:30P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of Death	ANTOINE	4c. County of	
	=/(411111	٠.	Seasons Hospi	ce			Randa	allstown		Ва	altimore
	Funeral		5. Social Security Number 6. S	9x 7. Ag	e (In yrs. la	st birthday)	If Under 1 Year		8. Date of Birth (Month, Day,		Birthplace (State or Foreign
	Director		171-26-5085	□м 27Д F	98	Yrs.	Months Days	Hours Min.	Oct. 1,		PA
	pr.		Usual Residence of Decedent								
	irylar show	_	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Ma 3a-f	cto	MD Baltim	ore		Reist	erstown				1 □Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wh	nat Country?
	23a		308 Stonecastle	Ave.			21136	5		Į	USA
	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Evant eur ouat be notified at	Funeral	11. Marital Status	12. Was Decedent in Armed Forces?		. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
36	orit	by Fi	1 Never Married 2 Married	1 ∐Yes 2 💢 I If Yes, Give	No		□Yes 21/2 No	Specify:	, ,	Specify:	·
5-0036	ural"	Q P	3 X Widowed 4 □ Divorced	Year or Dates:			**				White
5	"nat	lete	15. Decedent's Ed (Specify only highest gra	ucation de c <i>ompleted)</i>		(Give	lent's Usual Occup- kind of work done o	furing most of work	ing	16b. Kind of Busin	ness/Industry
121	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		OO NOT use retired)		0 . 1	D D
22	Hygi Hygi ther nt,		17. Father's Name (First, Middle, Last)			5a	les Lady	18. Mother's Name	e (First Middle M		Ray Drug
aŭ	l be i	Be								naiden odiname)	
Maryland	d 2 should be filed within 72 hours after death with the Marylan Ith and Mental Hygiene. If nand Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Mydical Exactions in at to notified at	၉	Harry Pellegrini 19a. Informant's Name/Relationship (7)	ima Brint)		40h M-III-	- Address (Chart		Artese	0" T 0	
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	es 1 and 2 of Health If item 27 i		Carol M. Campbell 20a. Method of Disposition	Daugl			tonecast	le Ave.,	Reisters	stown, MI	D 21136 ity or Town, State
altımore,		Н	1 ☐ Burial 2 🂢 Cremation 3 ☐		cei	metery, crem	natory or other plac	e)	Jale	200. Location - Cr	lty or rown, State
Ħ	t. Pa rtmei rtant rjury		4 □ Donation 5 □ Other (Specify		Carı		remation	3/4	/09	Hampste	ead, MD
g P	permit. Pages Department of Important: If if any Injury or once.		21. Signature of Funeral Service Licen	see 、			. Name and Addres	•		4 Reiste	erstown Road
	20200		1 samb (Cu	20				eral Home		terstown	
			23 . Part 1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each lir	ne.				. ,	est,	Approximate Interval Between Onset and Death
	Physician	4	Immediate Cause (Final else as a condition resulting in death)	a. Athey	0501	Grat	ic Hea	rt Dise	ase		Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):					
		_	Sequentially list conditions,	b		-					
٠,	led sit	in	cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence orp.					-
D	executed n and al-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):					
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98/90	ficate be e physiciar s the buria	edical		d							
	certif ding se as		IF FEMALE:	23c. If yes, outcome	of pregnan	cv				00.1.0.1	
X R R	death cert e attending d for use a	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3□	Ectopic pregnancy Other (specify)	1		23d. Date of Month	
o l	the d	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	t time or de	alli 5L	Other (specify)				
J.	that led by deta		Part II. Other significant conditions co	entributing to death be	ut not result	ting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
Vital Records,	ures r sign d be	d b							1 □ Ye	s 2 □ No 3	☐ Probably 4 🎇 Unknown
o S	v req beer shoul	ete							04- 14/	0.01-111	
Ŭ L	he lav e has ge 2	Completed							24a. Was ar autops perforn	y pric	ere autopsy findings available or to completion of cause of ath?
<u></u>	n: In ficate r, pa		05 W				,		1 □Yes 2	No 1□	Yes 2/2 No
5	sicia certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	26. Place of Death		CI	ASIMIS ITASVICE
0	rthis raldi	<u>:</u>	27. Manner of Death	1 ∐ Inpatie		R/Outpatien	3 DOA	4 □ Nursing Ho		nce 6 GOther	
ם י	ding h. Afte fune	ţi	1 Matural 5 ☐ Pending	(Month, Da	y, Year)	Injury	28c. Injury Work	? Yes 2 □ No	zou. Describe no	w injury occurred	
VISION	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ırv - At hom	ne, farm, stre			28f Location /Str	root and Number	or Rural Route Number,
2	after after Dire	Certification:	4 Homicide determined	building, etc	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	on tactory, online		City or Town	, State)	or nural noute Number,
-	spita lours neral r fillec		29a. Certifier 12 Certifying Phy	/siclan: To the best	of my know	ledge, death	occurred at the tin	ne, date and place,	and due to the ca	ause(s) and mann	ner as stated.
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. When Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exam	iner: On the basis of and manner sta	f examination	on and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and place, and	d due to the cause(s)
	Mithir To th	Me	29b. Signature and title of certifier	,			29c. License	number	29	d. Date signed (/	Month, Day, Year)
			> xel Lellyse	ulin			HL	15931		March	3 3008
	5	ŀ			eath (Item 2	23a) (Type. F					3 3001
	1		30. Name and address of person who a	wton	2835	Smi	the Nor	wo Sut	203 B	altimo	10 MO 21208
	Sta		31. Date filed (Month, Day, Year)	22 Detroicted	ar'e Signatu	ro					
	Registr	r	WAR 0 6 20	19 Due	w A	1. 1	alle				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06944 State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death rs. 8. Date of Birth lin. (Month, Day 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday).

Q | Yrs. **Funeral** Min. 1□ M 2**∑** F Months Days Hours 214-26-006 Usual Residence of Decedent Director North Carolina 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Modical Experiment up to notified at Director 1 Yes 2 □ No 10 imore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury or other traumatic event, the Manay Injury Inj College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ပ 19a. Infor ant's Name/Relationship Type. Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. e, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 D Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a P.O. I 9 Unknown Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 24a. Was an certificate has page 2 autopsy 2 **□**No 1 □Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖳 ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 57543 451C/A Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE ST, BALTIMORE MD 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State MAR 06

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Izetta Bryan 200 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Baltimore N/A Augsburg Lutheran Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 □ F 217-16-7040 89 Sep 28, 1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland **Baltimore City** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3600 West Franklin Street 21229 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 XWidowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration Clerk 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Labb Elizabeth Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene B. Warren 7 Chris Court Baltimore, Maryland 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/04/09 Crownsville, Md. Crownsville Veterans Cemetery 21. Signature of Funeral Service Li 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 23a. Part 1. Enter the disease, of complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Hyproschedic cerebra disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) 1 ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

> the burial-transi and

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To the Funeral Director: After th completely filled in by the funeral

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Certification: To

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10a. State

Funeral

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28a-f show

items 23a

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical

IF FEMALE:	

25. Was case referred to medical examiner?

1 Tes 2 No

27. Manner of Death

1-ANatural

2 Accident

3 Suicide

29a Certifier

4 Homicide

(Check only one)

24a. Was an autopsy perform 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one)

Other: AM Nursing Home 5 Residence 6 Other (Specify) Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Day, Year)

71136

37573

February 76,7009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sibell 3. Marin **22**

Hospital:

5 Pending investigation

6 ☐ Could not be

MAR 0 6 2009

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

egistrar's Signatur

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

State

filed within 72 hours after death Baltimore, Maryland 21215-0036 1 and 2 should be filed withi Health and Mental Hygiene. permit. Pages 1 and 2 Department of Health of Important: If item 27 is any Injury or other tra

The law requires that the death certificate be executed Box 68760, P.O. Records, of Vital Physician: Hospital or Attending Division death.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla	•	irtment of Hea <i>tificate of Dea</i>		, ,	200	0 00010
			Registrar 1. Decedent's Name (First, Middle, Last,)	061			Date of Death		3. Time of Death
	hysici: /Medic		NATHALIE I	RENE BERKEY			М	arch	Day Year 2.00	9 9:35 p. M
	Examin		4a. Facility Name (If not institution, give: Gilchrist Hospic			4b. City, Town, or Local Towson	ation of Death		4c. County of Dea	ith
e.	uneral		5. Social Security Number 8. Sec		s. last birthday)	If Under 1 Year If U	Under 24 Hrs. 8.	Date of Birth	9. Bir	
	rector		213-12-2648] M 2	90 Yrs.	Months Days Ho	ours Min. N	Date of Birth (Month, Day, Y OV . 17,	1918 Ma	rthplace (State or Foreign ountry) aryland
and	M.		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	eation				10d. Inside City Limits
Mary	Fed sh	tor	Maryland N/A	Ba	ltimore					1 ☐ Yes 2 ☐ No
th the	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
ath w	s 23a		814 Cedarcroft R		Fire	21212			U.S.A.	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	r than "natural", or items 23a or 28a-f show the Modical Exacilmet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒️ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes		Vas Decedent of Hispar FYes, specify Cuban, M □Yes XX No Sp	nic Origin? (Specif lexican, Puerto Ric pecify:		14. Race - Am Black, Whit Specify:	te, etc.
5-0	natura fical E	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Deced	ent's Usual Occupation	n most of working	16	b. Kind of Business	White /Industry
121 within	than "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+) 2 yrs.		kind of work done during DO NOT use retired) Cutive Assis			Can Manu	facture
filed THygin	other ent, II	Be Co	17. Father's Name (First, Middle, Last)		Line		Mother's Name (F			racture
Maryland 21 2 should be filed w h and Mental Hygier	arked atic ev	To B	William George Ecl	kstein		1	Nathalie			Ball
Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene.			19a. Informant's Name/Relationship (Ty William Berkey (Sc	pe. Print) on)	19b. Mailin 10817	g Address (Street and A Powers Ave	Number or Rural R • Cockeys	oute Number, C Sville, N	City or Town, State, Maryland	Zip Code) 21030
Pages 1	If item 2 or other		20a. Method of Disposition 1 N Surial 2 □ Cremation 3 □ R			sition (Name of patery or other place)	Date		c. Location - City or	
nit. Pa	Important: If i any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenter		-	S Cemetery	3-9-0			,Maryland
D Ped .	a and	l d	Creet Br	rah		Name and Address of 6500 Yo	ork Road	nell-Wie Baltimo	edeteld F ore,Maryla	.H. Inc. and 21212
			23a. Part 1. Enter the disease, or comp shock, or heart fallure. List only or	cations that caused the dea	ath. Do not ente					Approximate Interval Between
Phys	sician edical		Immediate Cause (Final disease or condition resulting in death)	Ischemic C		opathy				Onset and Death Months
	niner			years						
P	,e	ner	Sequentially list conditions, it my, leading Commediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atherosler Due to Gras a corse						years
xecute	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	oguence of):					
officate be executed	g physician and s the burial-transit			Due to (or as a conse	equence on.					
	ng phy as the	Medical	TE SERVICE			558			T s	
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To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. With the European Discover After this confineds how how signed by the	an signed I	þ	Part II. Other significant conditions cor Dementia	tributing to death but not re	esulting in the un	derlying cause given in	Part I.			o the cause of death?
eco law re	as be	Completed	Atrial Fibrillat	ion				24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
The	cate n	Son	Peripheral Vascu	lar Disease				performed	d? death?	s 2 □No
VITAL Sician: T	rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital:	7500	Othor	Place of Death (C		XZ	TI
g Phy	er this ieral d	2:	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		5 ☐ Residence. Describe how		ecify)Hospice
Attending Phy er death.	or: Af	atio	1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Monut, Day, rear)	пдигу	M 1 □Yes	2 □No			
or Att	in by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre cify)	et, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
Hospital 24 hours	etely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death	occurred at the time, diestigation, in my opinion	ate and place, and n, death occurred	due to the causat the time, date	se(s) and manner a	s stated. e to the cause(s)
To the within	Сощр	Me	29b. Signature and title of certifier	7		29c. License num	nber	29d.	Date signed (Mont	h, Day, Year)
) Del	2010		D 6439	5	Ma	arch 5,20	09
	1		30. Name and address of person who co Danielle Doberma:	n,MD 6565 N.	Charles	St. Suite	209 Bal	timore,	Md. 21204	
R	Stat Registra		31. Date filed (<i>Month, Day, Year</i>) MAR 0 6 2009	2. Registrar's Sign	ature for	W				

Registrar

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, per Fh g889 3/6/09 TT
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:40 PM nesti 2069 0 /Medical 4c. County of Death
Bill Himore 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MD Butmore -och Kaven Center benesis 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 K F 213309145 South Caroline Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Evanshine 5602 21206 V by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Saltimore, Maryland 21215-0036 Specify Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "na any injury or other traumatic event." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Homemaker Coilege (1-4or 5+) Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 14 UKn ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Serven Md 21144 Son COURT BRUNSON 200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 3/4/2009 1 Burial 2 □ Cremation 3 Removal from State Balto. md HIME RE 4 □ Donation /5 □ Other (Specify) 21. Signature o Funeral Service Licens 21213 Han Cha or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Oh48 ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an eutopsy performed? res 2 \(\) No certificate 1∐ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 28h. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral TE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) R113807 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and to MD SISKA 8726 Emge Rd Bal av 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year ALBERT **BERGER** Month MARCIT 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSPICE@NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/17/1921 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F 87 Director 220-09-2497 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evantics must be notified at once. 10a. State 10c, City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 □Yes 2√□No RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9114 MEADOW HEIGHTS ROAD Funeral 21133 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No WWIII
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ò WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE 12 OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JOSEPH** BERGER DORA RUDMAN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE BERGER / WIFE 9114 MEADOW HEIGHTS ROAD RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State PROGRESSIVE RUDOMER 03/05/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD PIKE
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myelogenous disease or condition resulting in death) /Medical Due to (or as a consequen / of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine by pie The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Dav Year 5 Other (specify) the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown , page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate pirator 1 □ Yes 1 ☐ Yes 2 🖾 No 2 🛱 No the Hospital or Attending Physiclan: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify NS 1+05PILE 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) To the within 2

State Registrar

29b. Signature and title of certifier

mith Avenue Surte 203

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month ERESA BROOKSHER 1 ARCH 01:56 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BALTIMORE BAYVIEW WEDCAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X**□ F 220-78-1981 Director Dec29,1961 NorthCarolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinatment be notified at once. Md. Baltimore Dundalk 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7827 St. Patricia Lane 21222 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ∐Yes 2 ☑ No if Yes, Give Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Nursing Assistant Nursing Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barney Edward Lee Barbara Jean Coley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7827 St. Patricia Lane Baltimore, Md. Cecil Brooksher (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory3-6-2009 Baltimore, Maryland 22. Name and Address of Facilitikaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) PNEUMONIA 6 days /Medical Due to (or as a consequence of): Examiner NON SMALL CELL LUNG CARCINOMA 18 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 Nio 1 🗆 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Will, MEDICAL DOLTOR SE2-000

State Registrar

JOHAS HOPICIAS MEDICAL CENTER, 4940 EASTERN AVE, BALT MORE, ALARYLAND VERENIQUE AUSIEMBUT 31. Date filed (Month, Day, Year) 32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR U 6 2008

March : 02, 2009

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Mary Elizabeth Crockett 5AM M 09 つる D 4b. City, Town, or Location of Death Randallstown 4a. Facility Name (If not institution, give street and number) Baltimore FutureCare Old Court 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 227-56-0370 1 M 3 T Months 1943Virginia 65 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Pikesville 1 ☐ Yes 🎗 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 602 Leafydale Terrace 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Secuity Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Stock Clerk Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Chambers Glossie Mae Chambers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Crockett/ Husband 602 Leafydale Terrace Pikesville, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 3 □ Bemoval from State Mt. Zion Cemetery Lansdowne, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Servi 5240 Reisterstown Rd Baltimore, Md 21215 e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Im Le Cause (Final di ease or condition resulting in death) 500 July 3000 Due to (or as a consequence of) chigaca Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). f yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1∐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Jeath (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

items 23a

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7 is marked other traumatic event, the

Department of Health a Important: If item 27 is any injury or other traconce.

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after

and Mental

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-tran physician a the burial attending p as nse for the signed by t page 2 should been has certificate ! Hospital or Attending Physician: funeral director, this After n 24 hours after death.

• Funeral Director: A pletely filled in by the fu death.

P.O. Box 68760, €

Division or Vital Records,

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant þ Completed Be 200.00 Certification: To 1 ☐ Yes 27. Manner eath

1 July ura

2 Accident

4 Homicide

(Check only

3∏ Suicide

29a. Certifier

in the past 12 months? 1 ☐ Yes 2 ☐ No

Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ∏Yes 2 ∏No

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Cov. ring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person

Medical

31. Date filed (Month, Day, Year) MAR 0 6 2009 State

cause of death (Item 23a) (Type, Print)

Registrar

within 24 hou **To the Fune** completely fi

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 27 2509 0157AM /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAVRE DE GRACE HOSPITAL Hemorial If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** 1 M 2 □ F 723 072-28-5377 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location nside City Limits other traumatic event, the Madical Examiner must be notified at HAVRE DE GRACE 1 ☐ Yes 2 No To Be Completed by Funeral Director 10g. Citizen of What Country? or iteme 23a or Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene.
Is marked other than self-employed College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ቜ /URNE Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To , State, Zip Code) las Campbell item 27 HANRE DE GRACE MO 21078 20a. Method of Disposition 20b. Place of Disposition (Name of Date Depertment of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee man-Harris Fureral Home 240 Reisters town Rual BACTO. MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Uncon /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner equence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deays? Completed by 4 Unknown 3 Probably 4b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Division of Vital Records, P.O. Box 68760 within 24 hours after death. To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detach Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lorge 30. Name and address of person who completed cause of dadd. (Item 23a) (Type, Print) 601-5. Lenion Grace Ud, 20178

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar Signature

09-01768 Margaret Gertrude	Crouse State of Maryland / Dep	Indelible Ink. Ensure All Copies partment of Health and Mental Hy	giene
<u>anning samuran samura</u>	Registrar	ertificate of Death	Reg. No. 2009 0695
Physician/ Medical Examine	Decedent's Name (First, Middle,Last) Margaret G. Crouse		2. Date of Death
17	Facility Name (if not institution, give street and number) 7957 Bank Street	4b. City, Town, or Location of Death Dundalk	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs 218-12-6991	s. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent	86 Yrs.	10d. Inside City Limits
daryland 28a-f show an Jat once	MD Baltimore	Dundalk	1 Yes 2 X No
Diffie he	10e. Street and Number 7957 Bank Street	10f. Zip Code 21224	10g. Citizen of What Country? USA
er death with the crutems 23 are must be not	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto I	
s after de rial", or i	or Dates:	1 Yes 2 X No specify:	Specify: White
5 72 hours at Exam leted	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use retire	
5-0036 led within 72 hour Hygrene. other than "nature the Medical Exau	8th 17. Father's Name (First, Middle, Last)	Secretery 18.Mother's Name	(First, Middle, Maiden Surname)
1215 Ibe file ental Hy went, th	Walter Crouse		Jordan
MD 21. d 2 should b. Ith and Mer. n 27 is man minuatic even	19a. Informant's Name/Relationship (Type, Print) Mary Dorn / sister	19b. Mailing Address (Street and Number or R 3632 Bay Drive B	ural Route Number, City or Town, State, Zip Code) altimore MD 21220
Ore, I of Healt of Healt If item		ob. Place of Disposition (Name of cemetery, crematory or other place) Dak Lawn Cemetery 3/6	Date 20c. Location - City or Town, State /09 Baltimore MD
Baltimore, permit, Pages I at Department of Hes Important: If ite Injury or other tr	4 Donation 5 Other Specify: 21. Signature of Duneral Service Licensee		00 Mace Ave. Balto. MD
M & A E E B Physician /Medical	23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on yach line.	YI Connelly Funer ath. Do not enter the mode of dying, such as cardiac or reaches atheroslcerotic cardio	Between Unset and
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Division of Vital Records, P.O. Box 68760, To the Hospital or Autending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functual Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of ping in the past 12 months? 1 Uve birth 4 Pregnant at time of grant in the pregnant at time of grant in the ping in the	2 Fetal death 3 Ectopic pregnal	23d. Date of delivery Month Day Year
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rds, Frequires been sign bould be			24a. Was an autopsy findings available prior to completion of cause of
of Vital Records, ing Physician: The law require After this certificate has been significant director, page 2 should be not To Be Completed			performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician: ician: certifi rector,	25. Was case referred to medical examiner?	26.Place of Death (Check of ER/Outpatient 3 DOA Other William Nursing	only one) g Home 5 Residence 6 ✔ Other: Scene
1 of Villing Phys. After this funeral di	1 ✓ Yes 2 No line in the second of the seco		28d. Describe how injury occurred
Division o ital or Attending urs after death. ral Director: Aft lled in by the fune ertification;	Natural 5 Pending Investigation Fd 3.2.200	J91 Fd 10:50 atm 1	probable fall
Divis spital or / hours after neral Dire filled in E	Suicide Could not be determined (Specify) house	At home, farm, street, factory, office building, etc. S E	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7057 Bank St Dundalk, MD
Di To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.	vledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
- 3 - 8 O	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30/20

30. Name and address of person who completed cause of death (Item 23a)

Pamela E. Southall, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Xear)
Registrar MAR 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Clifton 2009 9:40AM M S. 4, Roy March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carrol1 Dove House Westminster 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 17 M 2 □ F 214-16-9934 89 Director March 14,1919 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Marian Examination in Items to notified an once. Director 1 ☐ Yes 2 No Finksburg MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21048 <u>141 Lassiter Circle</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? 1 □Yes 2 XNo Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Hairdressing 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Charles H. Clifton Laura Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mazie E. Clifton Wife 141 Lassiter Circle, Finksburg, MD 21048 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ◯XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 3/6/09 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21136 Eline Funeral Home Reisterstown, MD 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one out-on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 12 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. 9 I Inknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? Records. No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 2 2 100 1 ∐ Yes 2 **1**No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury At home, farm, street, factory, office building, oc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the course Medical 29a, Certifier (Check only On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** CURRY JOHN march 1 200 9 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia **Howard County General Hospital** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours Director 88 028-12-8083 Nov 30, 1920 Usual Residence of Decedent nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. inside City Limits 10a, State 10b. County 1 ☐ Yes 2 XNo Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A. 5330 Dorsey Hall Dr. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 114 Yes 2 □ No 117 Yes, Give Black, White, etc. 1 Never Married 2 Married 943 1□Yes 2X No Baltimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher / Principal Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ John Bernard Curry, Sr. Marguerite Mahoney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1225 Haleys Ct. Mount Airy, MD 21771 Edward Curry - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mar 03, 2009 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature di Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 164 1 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Premoco cca **Physician** diséase or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2XNo Hospital: Other: 4 Nursing Home 5 Residence 1X Inpatient 2 ER/Outpatient 3□ DOA 1 Tes ို After this 6 ☐Other (Specify) 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 📈 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Backlier Medic Road Ballmul Maylans 201-109 Sabapally

Registrar

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician Month William Frank Chelf March 2, 12:15 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 8. Date of Birth (Month, Day, Year) **X**□M 2□F Months Days Hours Min. Director 1930 <u>218-26-4667</u> June 18, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be nottled at 10d. Inside City Limits Director 1 □Yes 2X No <u>Harford</u> Maryland Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3117 Queens Castle Court 21154 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married \$ 1 ☐ Yes 2 ☐XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other thar 8 Painter Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If iten 27 is marked any injury or other traumatic evone. Arthur Madison Chelf Sr. Mary May Sanford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Chelf / Wife 3117 Queens Castle Court, Street, Maryland, 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 3/6/2009 Bel Air, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. PC 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a ARTERIOSCLEROTIC CARDIOVASCULAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should PROSTATE 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Jas 2 🗆 No 1 ☐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2∐No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

P.O. Box 68760, Records, Vital ō Division

ours after death.

Hospital or Attending 24 hours a completely within 2

Medical Certification: To

3+1 31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 ☐ Homicide

(Check only one)

29a. Certifier

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BEL AIR

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 NORTH AVE M. ABHYANKAR

32. Registrar's Signatur

State Registrar

			For 1_ State	State of Maryla		artmen rtificate			and Me	ental Hy	giene		2.2		
			Registrar	-41	Ce	rinicai	e or L	Jeain			Reg. No.	20	09	. 0.5	95
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	Funeral		Future Care North 5. Social Security Number 6. S		s. last birthday)	If Under		If Under 2		B. Date of Bir	th		. Birthpla	ace (State o	or Foreign
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Baltimore,	ges 1 ar it of Hea if item or other		20a. Method of Disposition 1 ☐ Bunal 2 【XCremation 3 ☐	20b	. Place of Dispo cemetery, cre	osition (Nan matory or o	ne of ther plac	e)	Da	ite	20c. Lo	ocation - Ci	ty or Tov	vn, State	
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3alt	permit. Pages: Department of H Important: If ite any Injury or of		21. Signature of Funeral Service Licer	isee/	Į.	2. Name an	d Addres S Fu	is of Facilit neral	Home	e, P.A		•	4		
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	(11		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	Print)	. 1	, ,			1	(- 0	1		
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	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature	a del	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep 1 - State Registrar State of Maryland / Dep	partment of Health and ertificate of Death		/	9 06958
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	g. No.	3. Time of Death
	Physic /Medi		ETTA ETTADEMIT CATTANIAN		Month February	Day Ye	ar
- Mary	Exami			4b. City, Town, or Location of De		4c. County of D	
911	•		Brighton Gardens	Baltimore		Balt:	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth		Birthplace (State or Foreign
	Director		212-26-2469 1 M 2 K 81 Yrs.	Months Days Hours Mi	Mar. 17,	1927 Ma	Country) aryland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			
	/any	ō	i i i i i i i i i i i i i i i i i i i				10d. Inside City Limits
	the 1	rect	Maryland Baltimore Baltim				1 ☐ Yes 2 🛣 No
	with 3a or	Funeral Director	6451 N. Charles Street	10f. Zip Code	100	g. Citizen of What	
	ms 2	Jera	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Historic Origin?	(Specify Veg or No	U.S.A	
9	after o	E	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.)	Black, W	merican Indian, hite, etc.
8	ral", c	l b	3 X Widowed 4 □ Divorced If Yes, Give A Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: V	Mhite
21215-0036	72 ho 'natu	Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of w	, 16	6b. Kind of Busine	
12	ithin ne. han "	Ig m	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	orking		
2	led w Hygie her t	ပိ	12 years	Proprietor		Hair Sa	lon
anc	be fi	Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Ma	iden Surname)	
Ë	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Ergining must be notified at	은		Adele	Bric		
₹	id 2 s Ith ar 27 is trau			ing Address (Street and Number or F		City or Town, State	e, Zip Code)
<u>6</u>	f Hea		Louise Meledin (attny.) 406 20a. Method of Disposition 20b. Place of Disp	Bosley Ave. Towso osition (Name of matory or other place)		.04 c. Location - City	or Tourn Chate
30	ages ent o nt: If I		T - T - T - T - T - T - T - T - T - T -				,
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evol. The must be notified at once.		21. Signature of Funeral Service Licensee	ant Crematory 3- 2. Name and Address of Facility			, Maryland
m	Deg any	h	9 Joseph Ferranse	Mitchell-Wiedefel 6500 York Road	d Funeral	Home, In	C. 01010
			23a. Part onter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	Baltimore,	_Marylan	d 21212
4	Physician	i si	Immediate Cause (Final disease or condition		, , , , , , ,		Approximate Interval Between Onset and Death
	/Medical		resulting in death) a. Due to (or at a consequence of):				year
	Examiner		Sequentially list conditions				U
7	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last				
60,	ficate be executed physician and s the burial-transit	alE	Due to (or as a consequence of):				
28760	ficate phys s the	edical	d				
ROX	death certific e attending p d for use as	√/Me	IF FEMALE: 23h Was decedent program 23c. If yes, outcome of pregnancy				
ň	death a atte	iciai	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	elivery Day Year
J.	that the led by the detached	Physician/M	9 ☐ Unknown				
	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute	to the cause of death?
Kecords,	requires seen sign hould be		Dementia		1. √Yes	2 No 3 1	Probably 4 Unknown
ပ္ထ	10 m 01	Completed			24a. Was an	24h Were a	autopsy findings available
	The ate h	mo;			autopsy performed	prior to death?	completion of cause of
Ta	Physician; r this certific ral director, p	Be (25. Was case referred to medical examiner?	26. Place of De	1 ☐ Yes 2 ₩ ath (Check only one)	No 1 □Ye	s 2 No
0	hysic his call dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Otto	Home 5 ☐ Residence	e 6 ∏Other (So	ecify)
_	ing P		27. Many er of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) 28b. Time o	28c. Injury at Work?	28d. Describe how in		OUIIY
SIO	teath feath tor: /	cati	2 Accident Investigation 3 Suicide 6 Could not be	M 1 □Yes 2 □No			
UNISION	or Al	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or F tate)	Rural Route Number,
	pital		29a. Certifier 10 Certifying Physician: To the best of my knowledge deat				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Medical	29a. Certifier (Check only one) Medical Examiner: On the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and plac vestigation, in my opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	as stated. le to the cause(s)
	To the Hospital or Attending Physician; The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mon	th_Day, Year)
	,		> Seexer Victurel	037144		2/2/1	97
	10		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print)	A	יוטונ	1
	Ψ	ľ	Susan Molman MD, 10795 Fe	Us 14 Sufe 200	liethan	e NUD	203
	Stat Registra	-	31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 12. Registrar's Signature	Hal	/		
				•			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 06959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:500M Faye Caldwell /Medical Feb. 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 3008 Harlem Avenue Baltimore 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💥 94 Director 212-34-0936 Nov. 18, 1914 NC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location your l 10b. County 10d. Inside City Limits at Director MD N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3008 Harlem Avenue 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes ≱No þ Specify: Specify:Black 3 Widowed 4 □ Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home the Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd 2 should be fi Ith and Mental H 27 is marked otl Be Zack Moore Susan Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Vivian Caldwell/daughter 3008 Harlem Av.Baltimore,MD 21216 item 27 other t Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or ± 5 Arbutus, MD 3/4/2009 <u>Arbutus Mem.Pk.</u> 22. Name and Address of Facility Beverly Cromartie Fun. Svc. 21 Signature of Funeral Service License 2700Edmondson Av.Baltimore, MD21223 Comaile Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so near failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** MEEKS /Medical Due to (or as a consequence of): **Examiner** CARDIOMYOP WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed SEPTICE IN WEEKS burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHOLE CARLILIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown POTHYROIDISM 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No performe DEMEN 1∐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 TYes 2 No after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 ATTENDING 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) morrely in 00057216 MARCH 04, 2009 144 SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . mEADE PD, #209, LAUREL BAAKO, MD, 3450 PCT. mEADE PD, #209, LAUREL /32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR U 6 2800 Registrar

State of Maryland / Department of Health and Mental Hygieneo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day <u>Antonio Louis Castro,</u> 2009 March 9:30 PM /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c, County of Death Brinton Wood of Frankford City Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1**☑** M 2□ F Director 081-46-9930 Jan4. New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified an once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Rosedale Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2230 Hamiltowne Circle Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: þ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Security Guard Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Antonio Louis Castro, Sr. Carmen Mercado 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Gandarilla(sister) 2230 Hamiltowne Circle Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heartof Jesus 3-5-2009 Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 77 lud 1201 Dundalk Avenue Baltimore, Md. 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or 35 Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached f 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b rector, page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 20 No Other: 1 🗌 Yes ို 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred (Month, Day Year) 1 | Natural 5 Pending investigation 1 🔲 Yes 2 Accident 2 No after death Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

MAR 0 6 2009

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print) Wood

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Gwendolyn 5:04 P M February 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 M 2 KF 018-54-464 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural": or items 23a or 28a-f show any injury or other traumatic event 1 □Yes 2 🔽 🕠 Funeral Director 10g. Citizen of What Country? et and Number 10f Zin Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 21215-Elementary/Secondary (0-12) College (1-4or 5+) Be (17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) Reshound 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Method of Disposition Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastetic 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 9 I IInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marie Chatha POS (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Esther DiLegge :38 AM **Physician** Μ. March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE UNION MEMORIAL HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min 233-34-6259 1 M 2 F 83 Yrs. Director 3-6-1925 W. VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Sa or 28a-f show 10a. State 1 ☐ Yes 2 X No MD BALTIMORE ROSEDALE Director permit. Pages 1 and 2 should be filed within 72 hours after death with the M. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nace. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 U.S.A. 8605 DeLEGGE ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No WHITE þ Specify 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **CLORA** SMITH (GWINN) CLARENCE **JASON** J. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WAYNE DILEGGE/SON 8605 DeLEGGE ROAD ROSEDALE, MD 21237 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MORELAND MEMORIAL 3-7-2009 BALTIMORE, MD 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 years /Medical Due to (or as a consequence of): Examiner onar ears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner tension Der ear physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending properties for use as If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I 23e. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuer of Death 1 Natural Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death. e Funeral Director: A 2 Accident completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

within 2

State Registrar

Medical

29a Certifier

29b. Signature and title of certified

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 001 emoria

31. Date filed (Month, Day, Year) MAR 0 6 2009

and manner stated.

			Pleas		•						Ensure				_	е.		
		1 - For State Registrar			State	of Mai	rylan				lealth and Death	Me	ntal Hy	gien Reg. N	21111	9	069	63
Physi	cian	1. Decedent's Nar MARIE	ne (First, Middle	, Last)	LOI	JISE	2		D	OWNE	:N		Date of De	D	ay Ye	ar	3. Time of D	
/Med Exam	dica	4a. Facility Name		_	reet and n	umber)			4b. Cit	ty, Town, o	r Location of Dea		MARCH 2, 2009 4c. County of Death			7:06	Ρ™	
/ <u> </u>		5. Social Security		SPIC 6. Sex	CE CI			last birthday)	_	WSON ler 1 Year	If Under 24 Hr	's. g	. Date of Bi	rth			MORE place (State or	Foreign
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ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational by notified at	1	3 Widowed	rried 2□ Marrio		2. Was Dec Armed F 1 ∐Yes If Yes, G Year or I	orces? 2 XNo iive	ver in U.S			cedent of Hoecify Cuba	lispanic Origin? (an, Mexican, Pue Specify:	(Speci erto Ri	fy Yes or No can, etc.))-	14. Race - A Black, V Specify: W	/hite,	etc.	-
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director, page 2 should be detached for use as the total completely filled in by the funeral director.	Dhysician/Medical	23b. Was decede in the past 1 1 Tes 2 9 Unknow	2 months?	20	1 🗌 Live	birth 2 gnant at t	Fetal	I death 3[□ Ectopio □ Other	c pregnanc (specify)	у				23d. Date of Month	deliv		ear
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1 2009 Helen M. Davis March 2:06 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8414 Kavannaugh Road Baltimore Dundalk If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 XF 212-20-0300 Director 87 MD -13-1922 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State show ir than "natural", or items 23a or 28a-f showing Wedical Eranding at 1 Nes 2 No Director MD Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8414 Kavanaugh Road USA 21222 by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23 ary or other traumatic event, It we don't Exact in a coust Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Child CareWorker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Grams ပ <u>Catherine Grams</u> 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Schindler Daughter 7387 Edsworth Road Dundalk Mp 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3-6-09 Baltimore, MD 22. Name and Address of Facility 21. Signature Bradley-Ashton FUneral Home 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause peach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) zheimer's **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to hime dist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consecutiving of: Examiner sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by embell Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy perform 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number MO 30 Name am address of person who completed cause of death (Item 23a) (Type, Print)
MARIAN C. RUT (FLI ANO, W, 705) igital DR. SHIKG, LINTHICUM Heights 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06965 State of Maryland / Department of Health and Mental Hygiene 0 0 9 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 10:50 AM February Vilma Ramos Dunlap /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
Apr. 14, 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 X F 1961 Philippines Apr. 571-81-1058 47 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinating by notified at 1 ☐ Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 USA 508 Silverside Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo \$ 3 Widowed 4 Divorced Filipino "natural" Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier 12 Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erlinda (NMN) Sison ဂ္ဂ Gervacio (NMN) Ramos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyrone Dunlap / Husband 508 Silverside Road, Edgewood, Maryland, 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 3/7/2009 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** noxic Encephalopath disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Infarction Hospital or Attending Physician: The law requires that the death certificate be execute Acute Myocardial aftending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral D TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie ca (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

S. Zubair Khara 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1050

Baltimore,

50684008W

Box 68760

P.0.

Records,

Division of Vital

Dunlapi

29c. License number

500 Upper Chesapeake Dr. Bel Air, mp

13420

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2009 **Physician** Month Judith Ann Davis March 4, 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 🕏 F Months Days Hours Min Director 216**-**42-2064 66 29. Dec. 1942 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shevent, the Medical Examiner must be notified Director 1 XYes 2 □ No Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 F Timber Trail 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No þ Specify: 3 ☐ Widowed 4 A Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) f Health and Mental Hygiene. item 27 is marked other than College (1-4or 5+) 12 Teller Banking 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be lealth and Mental Frank J. Sperandeo ည Arlene K. (unk) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James I. Seybold / Son 220 F Timber Trail, Bel Air, MD 21014 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3-7-09 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) a. RECTAL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that initiated events resulting in death) Last and Due to (or as a consequence of): physician The law requires that the death certificate be Physician/Medical attending p If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 X No Month 5 Other (specify) Day Year ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2X No certificate 1 □Yes 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) ဂ္ 1 ☐ Yes 2 X No HOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier (Check only one) X Nurse Practition: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitionare is the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practitionare is the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 2 To the I 29b. Signature and the of certifier 29c. License numbe 29d. Date signe (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) egistrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

MAR 0 6 2009

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

of Vital Records,

Division

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney

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	Physici		1. Decedent's Name (First, Middle, Last) Marjorie	В. [EDELSO	N		2. Date of Death Month 5,	2009 Ye	3. Time of Death 1:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Casey House Montgomery Hos	nice		4b. City, Town, or Rockvi	Location of Deatl		4c. County of D	eath
	Funeral Director	Γ	0 0	<u>'</u>	st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9.1	Birthplace (State or Foreign Country) Alifornia
	D		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	8a-f sh	Director	Maryland Montgomery	Вє	ethesd	a				1 □Yes 2 No
	3a or 2	E Dir	10e. Street and Number 5501 Southwick Street			10f. Zip Code	0817	10g	United S	
036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show event, if a Medical Eventical must be I calified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	ver in U.S.	lf	las Decedent of H Yes, specify Cuba □Yes 2 No	ispanic Origin? (S n, Mexican, Puerti Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian,
15-0036	n 72 ho "natur edicel	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	ent's Usual Occupa ind of work done of O NOT use retired	ation furing most of work	king 16	b. Kind of Busine	ss/Industry
717	ed within /giene. er than	Comp	Elementary/Secondary (0-12) College (1-4or 5+ 5+)	Wri				Novels	
yland	ed Hall	To Be	17. Father's Name (First, Middle, Last) John Brown					ne (First, Middle, Mai Miller	iden Surname)	
>	a f F F		19a. Informant's Name/Relationship (<i>Type. Print</i>) Laurel Nelson, Daughter		7019	old Cabir	n Lane, F	ral Route Number, C Rockville,	Pity or Town, State MD 208	
pairimore	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation (5 □ Other (Specify)			tion (Name of atory or other place Eternity	03/10	i	Ima, CA	or Town, State
Dall	permit Depar Import any in		21. Sign ture of Fundari Service Licensee		Tổi	Name and Addres	Hebrew F	uneral Ho	me	00010
	Physician		23a. Part 1. Enter the disease, or complications that caused the state of the state		Do not ente	the mode of dying	g, such as cardiac	I, Washing or respiratory arrest	ton, DC	20012 Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a Hyperten	conseque	nce of):					
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury		nce of):					
,0070	tificate be executed g physician and as the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	conseque	nce of):					
00		Medical	IF FEMALE:							
	in that the death cert ned by the attending detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	Fetal d	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of o	lelivery Day Year
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A :	Pnysician: The Is this certificate haral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient			3 DOA Othe		h (Check only one)		
5 2	aing Pny h. After this funeral d	on: To	1 ☐ Yes 2 ☒ No 1 ☐ Inpatient 27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day, Worth, Day, Wo	28	8b. Time of Injury	28c. Injury Work	4 LI Nursing Ho	ome 5 Residence 28d. Describe how in		_{becify)} Hospice
O CIAIN	of the hospital of Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury building, etc.	y - At home (Specify)	e, farm, stree	M 1 □ Y	es 2□No	28f. Location (Stree City or Town, S.	t and Number or i	Rural Route Number,
	Funeral letely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examinatio	edge, death on and/or inve	occurred at the time stigation, in my op	e, date and place, inion, death occur	and due to the caus	e(s) and manner and place, and di	as stated. ue to the cause(s)
ļ	vithin To the compl	Me	29b. Signature and title of certifler Decelyne Kouchchou		ns	29c. License	number 63 748		Date signed (Mor	
,	8		30. Name and address of person who completed cause of dea Jocelyne Kouatchou, M.D., 6	ath (Item 2	3a) (Type, Pr	int)			MD 2085	5
	Stat Registra		31. Date filed (Month, Day, Year) 33. Registrar's	-						
НМ	H 17 Rev 1/20	001	MAR 0 6 2009 Senina	A.	gar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland	-	artment of H			ene 3. No 2009	06968
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	Evons			h	2. Date of Death Month ABCH	Day Year	3. Time of Death 9 0130M
	Examin Funeral		4a. Facility Name (If not institution, give 1. 29.22. 20.000) 5. Social Security Number 6. Security Number	view 120	st birthday)	130T	Location of Death Mulke If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	th o l
Jan.	Director		Usual Residence of Decedent	M 2XF 93	Yrs.	Months Days	Hours Min.	(Month, Day,)		o. Carolina
	ne Marylar 8a-f show otified at	Director	10a. State 10b. County Maryland N/A		Town or Lo	Ва	ltimore			10d. Inside City Limits 1 X Yes 2 □ No
	ath with t 23a or 2 ust be n		10e. Street and Number 2922 Round Road			10f. Zip Code	21225		g. Citizen of What Co U.S	,
5-0036	be filed within 72 hours after death with the Maryland Hygiene. at Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2☑ No	spanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
)-CLZLZ	J within 72 ho giene. r than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	OO NOT use retired	lurina most of worki	ng 16	6b. Kind of Business	Industry / Hospital
land 7	be od o	To Be C	17. Father's Name (First, Middle, Last) Theodore	Hammett			18. Mother's Name	•	aiden Surname) ia Hammett	
, Mar)	d 2 sh th and t7 Is rr traurr	ľ	19a. Informant's Name/Relationship (Ty) Dexter White	pe. Print)					City or Town, State, a	Zip Code)
ilmore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	2	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	metery, cren	sition (Name of natory or other place Zion Cemeter	e) ¦	20 03/06/09	C. Location - City or Lansdowne	
Balt	Departition Depart		21. Signature 15 in ral Service License	Mall 1		Name and Addres. Estep Br 1300 Eu	others Funera	al Service, P. timore, Md 2	A. 1217	
1	Physician /Medical Examiner) 	23a. Part1. En of the disease, or complishock, or leart failure. List only or Immediate cruse (Final disease or condition resulting in death)	cations that caused the leath. the cause on each line. Due to (or is a conse lie	mia	er the mode of dying	g, such as cardiac c	or respiratory arres	t, 	Approximate Interval Between Onset and Death
6	ate be executed sysician and ne burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conseque	Ren	n Fo	no Tue			34VS
09/90	physician and the burial-train	ical		Dener						Zyrs
.O. DOX	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of deal 9 □ Unknown	léath 3□	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ecords, P	equires that en signed b ruld be deta	by	Part II. Other significant conditions cor	tributing to death but not result	ing in the un	derlying cause give	en in Part I.		cco use contribute to	the cause of death?
al necc	The law re cate has be	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
OII OI VIIA	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 You 27. Manner of Death Natural 5 Pending investigation		R/Outpatient 28b. Time of Injury	28c. Injury Work	at Nursing Hor	N 4	ce 6 □Other (Specinjury occurred	city)
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 29 Medical Examination 29b. Signature and title of certifier	elcian: To the best of my knowler: On the basis of examination and manner stated.	edge, death on and/or inv	occurred at the timestigation, in my op	pinion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
	F ≥ 6		Jeny Se	cum of death (them 6	Am.	D2	5373		nc4 03,	
	Sta	at e	30 Name and address of person who co		m					
*	Registr		MAR 0 6 2009	3 Registrar's Signat	par	N. S.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** 9:55 P M Kathryn March 4 2009 King Eury /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 31, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🕱 F Yrs. 93 1915 Maryland Director 219-12-0088 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 21X No Director Maryland Frederick Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9602 Clemsonville Rd. 21791 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. <u>გ</u> Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) seamstress clothing factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel A. King Rosa Selby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any Injury or other trau Lynn Schenkelberg/granddaughter 9602 Clemsonville Rd. Union Bridge, MD 21791 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Linganore Cemetery 3/7/2009 Unionville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service License 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ HO Month Day 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 N 1 ☐ Yes 1 ☐ Yes Physiclan: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ \square Other (Specify) hospice 1 ☐ Yes 2 **N** Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of spital or Attending Poors after death.
neral Director: After the filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature

Registrar

State

31. Date filed (Month, Day, Year)

0 6 2009

s of person who completed cause of death (Item 23a) (Type, Print)

A MG n 3 Kanex 349 N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 06970 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex / 1 M 2 ☐ F (In yrs. last birthday 8. Date of Birth Birthplace (State or Foreign Country) Months Min Davs Hours Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BH 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NOR 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. 3 ₩ Widowed 4 □ Divorced Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

WOODLAWN

Approximate Interval Between Onset and Death

mon

HARFORD RO. PARKVILLE

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event in a rust be notified at

Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

10a State

3218

Elementary/Secondary (0-12)

20a. MetMod of Disposition

Immediate Cause (Final

disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

15. Decedent's Education (Specify only highest grade completed)

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

College (1-4or 5+)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a cons, quence of):

Due to (or as a consequence of)

Director

Funeral

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Completed

Be ပ္

Funeral

Director

Examine

physician and the burial-transit þ Completed Be

The law requires that the ceath certificate be executed Box 68760. o ۵. Records. Division of Vital death.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day signed by the a 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been s rector, page 2 should 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **W**Nc 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 MResidence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** cdonia Month Day Year Fulton /Medical lebruary 26,2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore W. TayeTTE Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1938 MARY Land **Funeral** 1 □ M 2 F Months 218-30-Director 6115 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Exar it air must be notified at Director MAN Baltimore 1 Pres 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ,o 1 ☐ Yes 2 ☐ No Specify: ģ 3 ₩idowed 4 Divorced BLack "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. College (1-4or 5+) er l'Ale 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Rank UKRS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip, Code) Street 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARbulus 4 Donation 5 Other (Specify) of Purperty 22. Name and Address of Facility wites Backo. The. 23a/Part 1. Enter the disease or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac Approximate Interval Between Onset and Death r respiratory arrest, Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of) Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ð oBSTEVE TIVE Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physiclan: director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

nd address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06972 for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month WILLIAMS GREEN. 3.009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 5. Social Security Number (In yrs. last birthday) 8. Date of Birth Sex. M 2□ F 9. Birthplace (State or Foreign Months Days Hours Min 213-28-7158 lary/and Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Inside City Limits 1 □Yes 2 No 10f. Zip Code 10g. Citizen of What Country? USA 2100 12. Was Decedent Ever in U.S. Acced Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RUCK DRIVE 17. Father's Nam (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) WILLAM GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) rdeen NO 2100, Cornell Lencia 20a. Method of Disposition
1 Durial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 3 ☐ Removal from State Battrowe HD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugleral Service Licensee 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence Dueto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): wyte. Due to (a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed Yes 2 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes /2 NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner requires that the death certificate be executed and the burial-trar attending physician use as

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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t commoletely filled in by the funera

funeral

Physician

/Medical

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Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examiner must be notified at

1 and 2 should be filed within Health and Mental Hygiene.

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permit. Pages Department of Important: If it any injury or c

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cati	

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 30 Name ape address of person who completed cause of death (Item 23a) (Type, Print) 09

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) MAR 0 6 2009

5 Pending investigation

6 Could not be determined

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Thelma F. GLASER 2009 8:52 P /Medical March 4. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oyear) 1918 Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 ☐ M 2 🔽 F 90 213-40-0008 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 27 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 20904 11621 New Hampshire Ave., #225 United States death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: white altimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: 3 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ifiled within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Saleswoman Furniture d 2 should be filed w th and Mental Hygier 7 is marked other th traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Vogelstein Abraham Aaron Flashman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an ant: If item 27 is ury or other trau Ruth Brodsky, Daughter 2012 Serpentine Terrace, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State injury or Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Beth Tfiloh Cemetery 03/06/09 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home Approximate Interval Betw 254 Carroll St. NW. Washington, DC enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Year'S **Physician** Aortic Stenosis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed physician and is the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as attending IF FEMALE: asn If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for t in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease, Essential Hypertension, 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Alzheimer's Disease certificate has autopsy performe 2 No 1 director, 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Assisted 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Inpatient this funeral 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) Living 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 2395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Run T. Feldman MD 3305 N. Leisure World B) M. 10 relde 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 6 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month RCHPay3 **Physician** 20019 Nora E. Greene 11:07FM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center imore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 234-30-7464 88 Yrs Director 11/18/1920 West Virginia Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Exercitival must be notified at Baltimore Director Maryland Nottingham 1 ☐ Yes 2 CKNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 63 Willow Path Court 21236 Funeral of America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married **2√X**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo 2 Specify white Specify: 3 Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Heating & and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) self employed Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Pearl Eskew Pearl Rutherford Pages 1 and 2 should ၉ Health and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other tra Craig Vacovsky/ grandson 2605 Claret Drive Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel Bell Air 20a. Method of Disposition 20c. Location - City or Town, State March 9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 2009 4 Donation Forest Hill, Maryland 21. Signature of Funeral Service Licenses eacerul Adres Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 1.1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DILATED CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ACUTE MYOCARDIAL INFARCTION and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mon 1 Yes 2 No Month Day Year 5 Other (specify) the detached 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No 1 Tyes 1 ☐ Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death funeral Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury investigation after death 2 Accident 1 ☐ Yes 2 ☐ No the 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2 To the I 29b. Signature and title of certif 29c. License number 29d. Date sig ned (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY 7601 OSLER DRIVE TOWSON, MARYLAND LOW.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Daniel George	1- For Sta	S	tate of Maryla	nd / Dep		Health and			ene	. No. 2 (nng n697
Physician/ Medical Examine		ent's Name (First, Mid ANIEL GEOR		6 1					ate of Death onth I bruary 25	Day Year 5, 2009	3. Time of Death 2331 hrs
(Y	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.						Date of Birth	4c. County of J	Death 9. Birthplace (State or Foreign		
čuneral Director	213-	-34-1809	1 XM 2 F	71	Yrs	Months Days		7.4.0	7/25/		PA.
or 28a-f show any fifted at once.	10a. Stat	e 10b. County	TIMORE	10c. City	EASTV				100	g. Citizen of What	10d. Inside City Limits 1 Yes 2 X No t Country?
vith the Maryland s 23a or 28a-f sh a routified at once		83 GOUGH S		edent Ever in U	J.S. 13. Wa	21224		? (Specify	UI	NITED ST	-
s after death v	11. Marital Status 1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the completed) 16a. Decedent's Usual Occupation (Give kind of the completed)						uerto Ricar	n, etc.)	White, of Specify:	WHITE	
5-0036 ed within 72 hour lygiene. to ther than "nature he Medical Exau	Eleme	ntary/Secondary (0-12 12TH	College (1		during m	ost of working life.	DO NOT us	se retired)		STEEL C	OMPANY
11215-0 Id be filed w fental Hygi narked othe event, the l	DA	er's Name (First, Middl NIEL GEORG rmant's Name/Relation	E, SR		19h Mailin	g Address (Stree	JEAN	BONA	CEIT	aiden Surname)	State, Zip Code)
re, MD 21 s I and 2 should f Health and Me If item 27 is ma er traumatir ev	NAN 20a. Met	NCY NEUMAN hod of Disposition urial 2 Cremati	/SISTER		28 TU	RNER LAN	E, MT		CO, NE	W YORK	
Baltimo permit Pages Department o Important: I	4 D	onation 5 Other ature of Funeral Service	Specify		22.	CEMETERY Name and Address 24 EASTE	-		LES S.	ZEILER	RE, MARYLAND & SON, INC. YLAND 21224
Physician /Medical Examiner	23a. Part I. Enter the disease, or corrections that the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Segmentially list conditions, b. Approximate in Between Onse Death Due to (or as a consequence of):							Approximate Interval Between Onset and			
executed ian and ial - transit	- 1	Enter Underlying Cause or injury that initiated esulting in death) Las	C.		,	rMe G891	5/12	/09 T	r		
Sox 68760, death certificate by the attending physic of for use as the bur overcician/Mer	IF FEMA 23b. Was past	LE: decedent pregnant in 12 months? es 2 No 9 L	the 1 Live b 4 Pregrand	ant at time of o	2 Fordeath 5 0	etal death 3 ther (Specify)		pregnancy		23d. Date of d Month	elivery Day Year
Division of Vital Records, P.O. Boy within 24 hours after death within 24 hours after death. The law requires that the death to the Funeral Director. After this certificate has been signed by the att completely filled in by the funeral director, page 2 should be detached for pacifical Certification. To Be Completed by Physical Certification.	cı		tructive p				given in Part	I. 	1 Yes 24a. Was a autops perfore	2 No 3 24b. W	ute to the cause of death? Probably 4 Vunknown ere autopsy findings available for to completion of cause of lath?
II Re		case referred to medi-	cal				of Death (C	Check only	1 Yes 2 one)	No 1	Yes 2 No
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	27 Manu		Hospital: 1 28a. Date (Month yestigation	of Injury ı, Day,Year)	ER/Outpatien 28b. Time of	Injury 28c. Inju	ry at Work?	No	. Describe h	Residence 6 ow injury occurre	
Division o Hospital or Attending 24 hours after death reneral Director: Afteredy filled in by the fume		Suicide 6 Co de Homicide	ould not be termined (Specify)			eet, factory, office b			or Town, St	ate)	r or Rural Route Number, City
To the He within 24 To the Fu complete	(Check or one)		Physician: To the bes caminer:On the basis and manner s	of examination	edge, death occu and/or investiga	ation, in my opinion	, death occi	e, and due urred at the	to the cause time, date a	and place, and du	e to the cause(s)
		nature and title of cert	on who could led cau	se of death /tte	em 23a)	29c. Licens				29d. Date signed February 26	i, 2009
	Rus	ssell Alexander M	ID. Assistant N	/ledical Exa	iminer 11	1 Penn Street,	Baltimor	e, MD 2	1201		
Stat Registra	~	filed (Month, Day, Yea	/	egistrar's Signa	fact	_					
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** George Mitchell Griffith, Jr. 6:00 PM Feb 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Woodbridge Valley Manor Care Catonsville Baltimore If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 MM 2□ F Months Director 218-14-0742 MD May 14, 1923 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County or 28a-f show other traumatic event, the Medical Examinar roust be notified at 1 ☐ Yes 2 No Director MD Howard **Ellicott City** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 5034 IIchester Rd. 21043 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene, important: If feen 27 is marked other than "na any injury or other traumatic event and once. College (1-4or 5+) Elementary/Secondary (0-12) Sales Insurance 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George M. Griffith Sr. Marjorie Reeves Davis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5034 IIchester Rd. Ellicott City, MD 21043 George Griffith, III - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Pine Grove Cemetery** Mar 07, 2009 Mt. Airy, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a Part 1 Pour the disor complications that, aused the death, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner eum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death.
Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□No 1 □Yes 2 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 AL 8 2 Q 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 06

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

DHMH 17 Rev 1/2001

Registrar

		1 - State of Maryland / Dep	partment of Health and leartificate of Death	, ,	ene a. N ₂ 2009 06978
		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Physicia /Medic		Alfred W. Harris		Februar:	у ^{Day} 22, 2009 7:04 Р м
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	h	4c. County of Death
		Joseph Ritchey Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Baltimore J If Under 1 Year If Under 24 Hrs.	Don't of Disth	MA
Funeral Director		0 85 - 44 - 357 1 IXM 2 □ F 61 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Pay,) OCL • 18,	(State or Foreign Country) Monrobia
p.		Usual Residence of Decedent			
shov	ŏ	10a. State 10b. County 10c. City, Town or I Baltimo			10d. Inside City Limits 1
the N	rect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
h with 23a or	a D	3000 Reisterstown Road	7/2/5	_	United States
ems serve	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian,
5-0036 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinant be prolified at	Completed by Funeral Director	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	o rilcan, etc.)	Black, White, etc. Specify: Black
21215-0036 d within 72 hours aft glene. er than "natural", or , tre Modical Exp. ii	led k	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Sb. Kind of Business/Industry
215 thin 72 an "na Medi	nple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	king	,
ed wit lygien ft, ins	S	2	Maintenance		Safeway
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinant beneditied at once.	Be	17. Father's Name (First, Middle, Last) Edwin C. Harris		ne (First, Middle, Ma	iden Surname)
faryl	٩		ling Address (Street and Number or Ru	a Moore	City or Tayun State 7in Code
re, Ma Tand 2:: Health a tem 27 is			James Street, Syra		
Baltimore, permit. Pages 1 ar Department of Hee mportant: If item any injury or othe					c. Location - City or Town, State
Baltimor permit. Pages Department of I Important: If ite any injury or o		4 □ Donation 5 □ Other (Specify) Atlantic	Crematory 03/03		len Burnie, Maryland
Balt permit. Departr Imports any inju					neral Home, PA
	_	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2829 Hudson Street	-	
Physician		23a. Part1. Enter the disease, by complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest	Onset and Death
/Medical		disease or condition resulting in death) a. Ye atocking to the following in death) Due to (or as a consequence of):	ar carcinoma		2 months
Examiner	_	Sequentially list conditions, b.			
ig W eq	nine	if any, leading to immediate cause. Enter underlying Cause (Disease or injury			
execu n and al-trar	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):			
	dical	d			
c 68 ertifica ing ph	Med	IF FEMALE:			
Box 6 death certifi e attending p d for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	Jysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		monar Bay roa
IS, P.	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Cord: w require s been sig	ed	Hepatitis B Hypertension		1 □ Yes	2 No 3 Probably 4 Unknown
Peco	Completed	Hypertension		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Re sician: The li certificate ha rector, page 2				performed 1 □ Yes 2 □	d? death?
Vit siciar certif	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ FR/Outpatient	Other	th (Check only one)	
g Physer this eral di	n: 10	27. Manner of Death 28a. Date of Injury 28b. Time of	ALI Nursing Ho	ome 5 Residence 28d. Describe how i	e 6 Sother (Specify) HOSPICE
Sion (trending F leath. tor: After the funer	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No		.,,
Division of Vital Records, of or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	ot and Number or Rural Route Number, State)
pital or Al ours after o eral Direc filled in by		29a. Certifier 1 Certifying Physician: To the best of my knowledge dea	th account of the first of the		
Hos Hos Fun tely	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rvestigation, in my opinion, death occur	, and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the within 2 To the Comple	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		Jum 40lle 40	D51788		2-23-2009
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	MA 0 :	611
State		31. Date filed (Month, Day, Year) 32. Registrar's Signature	iton St. Bel Air	- FID 21	1014
Registra	r	31. Date filed (Month, Day, Year) NAR 0 6 2009 32. Registrar's Signature			

Baltimore, Maryland 21215-0036

filed within 72 hours after death with the Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend it em 30 per Ave 2889 13 6 09 th and Mental Hygiene 1 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 03 c 3 Har mon 2003 6:48 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOPKINS BAYVIEW BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Min. | June 4, 1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-38-1188 n IM 2∏F 68 Yrs. Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "neturel", or Items 23a or 28a-f show treumatic event, the Medical Examinations to such 10d. Inside City Limits MD Baltimore Dundalk Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8112 Murray Point Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 ☐ Xo Specify: þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bindery Printing 8th permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Harmon Elizabeth Gardner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Cain / daughter 315 N. Essex Avenue Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 3/7/09 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Septice Licensee 22. Name and Address of Facility 300 ^{2. Name and Address of Facility} 300 Mace Ave. Bal² Connelly Funeral Home of Essex 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA CARDIAC Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a. Certifier Example Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Physician /Medical Examiner The law requires that the death certificate be executed burial-transit attending physician for use as the buria Division of Vital Records, P.O. Box 68760 signed by the a d be detached f To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A

29b. Signature and title of certifier Marwan Abougergi

MARWAN ABOUGERGI, M.D. 29c. License number

29d. Date signed (Month, Day, Year)

03,03,2009

person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Ave. Balto. Md. 21224

31. Date filed (Month, Day, Year) MAR 0 6 2009



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06980 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death .^{Day}2009 **Physician** Feb. 28, Mari Marqueri eal 2:30 A M /Medical Facility Name of not institution, give street and number, St. Martin's Home / Litt] give street and number) 4b. City. Jown, or Location of Death 4c. County of Death Examiner le Sisters the Poor δf Catonsville Baltimore Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 8, 1 **Funeral** 343-16-3008 1 □ M 2 1 F Months Days Hours Min Director 1912 Ireland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits MD Baltimore Catonsville Director 1 ☐ Yes 2 No Street and Number 601 Maiden Choice Lane 10g. Citizen of What Country? 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No White Specify. ð ₩Widowed 4 □ Divorced al Hygiene. other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elder Care Religious Sister permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any luiny or other traumatic event ance. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Collins Margaret McMahon ပ 19a. informant's Name/Relationship (Type. Print)
Sr. Mary Frances Healy, daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 185 Salem Church Rd. Newark, DE 19713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 03-04-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Anhorose Funeral Home, Inc 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and Hospital or Attending Physician: The law requires that the death certificate be executed (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 Other (specify) the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autonsy certificate performe 1 ☐ Yes 2 ☐ No 2.25No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one the 29b. Signature and title of certified 29c. License number 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SAMBAN.

31. Date filed (Month, Day, Year)

MAR 0 6 2009

N. LKENS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 06981 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician William Hubal 9:05 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Square Center altimore 8. Date of Birth Feb. 18,1922 Birthplace (State or Foreign Country) **Funeral** Hours 183-14-5037 1 **3** M 2 □ F Months Days Min 87 Director PA Usual Residence of Decedent 10a State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits Middle River Baltimore Director MD 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 21220 204 Midlass Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★TYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 🛣 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector Aircraft Is marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) æ Alex Hubal Anna Gllant ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Midlass Drive Baltimore MD 21220 Emma Hubal 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Cemetery 3/7/09 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 the state caused the death. By not enter the mode of dying, such as cardiac or respiratory arrest, is cause on each line. 23a. Part 1. Enter the disease, or compli shock, or heart failure. List enly of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arres ardiac /Medical Due to (or as a consequence of): Examiner Infaction MVOCARO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Neuro musco Due to (or as a consequence of): and attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy this certificate perform 1 □Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manyler of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, filled in by the funeral within 24 hours after deatl To the Funeral Director:

investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50000

Drive

Registrar

Medical

31. Date filed (Month, Day, Year,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Harrington Year LIVSSES 19:58 PM 2009 March 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dear Hospital Baltimore city of 8. Date of Birth (Month, Day, July 15) 9. Birthplace (State or Foreign Country) Age (In vrs. last birthday) 1 M 2 □ F 217-18-6149 Months Hours Min P5 Yrs Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 2216 KoKo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify: Black Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EllioH Minnie Blakne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Voris Finley 4003 W. Forest Park Ave. Battimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 Cremation 3 Removal from State Garrison Forest Vet. OWINGS Mills Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License (ex Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final epilepticus disease or condition resulting in death) 4 days Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Pulmonary 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【■ No 24a. Was an autopsy performed? 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician and for use as the burial-trar

Physician

/Medical

Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Maxical Examinat is ust be notified at

and 2 should be filed within 72 hours after sath and Mental Hygiene.

Department of Health and Mental Hygi Important: If item 27 is marked other

Pages 1

21215-0036

Baltimore, Maryland

Completed by Funeral Director

Be (

within 24 hours a To the Funeral D

State Registrar

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Completed Be 25. Was case referred to medical 1 Yes 2 No Certification: To 27. Manner of Death 5 Pending investigation 1 🔏 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. Kusuma RES-000 March H, 2009

31. Date filed (Month, Day, Year)

KUSUMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANAPARTHI

MO

09-01646 Samuel W. Hill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1-For State Registrar State of Maryland / Department of Health and Mental I Certificate of Death		eg. No.	00000
Physic Medical Exam			2. Date of Dea	th. 20	8. Time of Death
medicai Exai		Samuel Walter Hill 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	February :	25, 2009	1502 hrs
gar.		1709 Edgewood Road Edgewood		Harford	eath .
Funera Directo		5. Social Security Number 402-66-5012 6. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Months Days Hours M		th(MM/DD/YYYY) \$ /1949	Birthplace (State or Foreign Country) Kentucky
y		Usual Residence of Decedent			1.0.1.0.1.1
d how as		7/A Friefry Chrinafield			10d. Inside City Limits 1 Yes 2 XNo
ne Maryland or 28a-f show any fied at once.	Director	10e. Street and Number 10f. Zip Code	110	0g. Citizen of What	
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nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland and Fleafith and Mental Hygiene. If: If item 27 is marked other than "natural", or items 23a or 28a-f sho olther traumaite event, the Medical Examiner must be notified at once.	v Funeral		Specify Yes or No- to Rican, etc.)	White, e	merican Indian, Black, tc. White
hours e	ed by		f work done	16b. Kind of Busine	
5-0036 led within 72 hours at yigiene, other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) S+ Major	etired)	US Army	
15-(filed v al Hygi ed oth	ပိ	17. Father's Name (First, Middle, Last) Walter Hill 18. Mother's Nam	ne (First, Middle, N	Maiden Surname)	
212 212 201d be Menta mark	To Be	19b. Mailing Address. (Street and Number or	tie Wilm	a Adams	7. 0
MD d 2 sho fth and n 27 is	[Wendy Sayles Hill, Wife 7583 Ruxton Drive,	Springfi	eld, VA 2	2153
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Heafth and Merhal Hygiene. Important: If item 27 is marked other than "matur injury or other traumanic event, the Medical Exam		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other Specific 20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory 03/	Date 701/2009	20c. Location - Cit	
Saltin rmit: epartm		21. Signature of Fur ral x rvi Lx nsee Harman 22. Name and Address of Facility Da			•
	_	616 Chestnut Stre	et, Bere	ea, KY 404	103
Physician /Medical		23a. P It I. Enter the I sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) A Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
	- o	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
1/	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C.			
ecuted and		events resulting in death) Last Due to (or as a consequence of): d.			200
al an	Medical	UNPENDED AMENDED			
		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deli	very
Box 68 death certif he attending d for use as	cian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregn.	ancy	Month	Day Year
P.O. Box 68: that the death certifi ned by the attending detached for use as t	Physician	1 Yes 2 No 9 Unknown g Unknown			
res that the signed by be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic alcohol abuse			to the cause of death?
ords, w requires ss been sig	eted	Circuite alcortor abuse	1 Yes		Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed by		autops perforn	y prior	autopsy findings available to completion of cause of
of Vital Reciing Physician: The After this certificate functal director, page		25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes 2		
Vita hysicia this ce	o Be	examiner? Hospital: Other:		tesidence 6 🗸 Ot	her: Scene
n of ding Ph After	Ju: T	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?		w injury occurred	
ivisior or Attencafter death Director:	catic	2 Accident Investigation Inves			
Divi	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify)	28f. Location (Str or Town, Sta	reet and Number or ite)	Rural Route Number, City
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause at the time, date ar	(s) and manner as s	tated.
FSFO	ž	29b. Signature and title of certifier 29c. License number		29d. Date signed (A	Month, Day, Year)
		Calmer O.C.M.E.		February 26, 2	009
19+1		 Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21. 	201		
St	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	201	<u> </u>	
Regist		MAR 0 6 2009 Jenus S. Jake			
DHMH 17 Rev 1/20	001	ORIGINAL			

OCME 2006

State of Maryland / Department of Health and Mental Hygiene 06984 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Sheila Byrd Hill 7:16 p /Medical Mar 1, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16 Court Wood Drive Pikesville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M & F Director 217-62-9107 Feb 4, 1955 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov Director Yes 2 No Maryland N/A Pikesville death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Court Wood Drive Funeral 21208 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Department of Health and Mental Hygiene. Important: If item Z71s marked other than "natural", or item any injury or other traumatic event, I'm Medical Exertine. once. 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Massage Parlor Massage Therapist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bobbie Friend ည Bertha Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Hill 2600 Essex Road Baltimore, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1) Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/07/09 Maryland National Park Cemetery Laurel, Maryland 21. Signature of Fineral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P 1300 Eutaw Place Baltimore, Md 21217 po not enter the mode of dying, such as cardiac or respiratory arrest 23a Part1 Enter the disease, or complications that caused the death. shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PASTROINTESTINAL BUEFOIM HOURS disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner Due to (or as a contequence of): VARICE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WEEKS Examine law requires that the death certificate be executed sician and burial-trans HEPATOCELLULAR CARCINOMA. Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical HRONIC HEPATITIS C IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform Division of Vital 2 X No 1 ☐ Yes 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Hospital or Attending** 1 ▼ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hin 24 hours after deatl the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 0 29d. Date signed (Month, Day, Year) D64395 MARCH 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHARLES ST, SUITE 209 BALTIMOTE, MD 21204 DOBERMAN, MD DANIEULE 31. Date filed (Month, Day, Year) 2 Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Judea rone 3009 /Medical Facility Name (If not institution. give street and number City, Town, or Location of Death 4c. County of Death Examiner MORE N/A Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 1 ▼ M 2 □ F Months Days Hours Min Yrs Director 216-48-8871 60 Maryland Oct 5, 1948 Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f st event, the Medical Examinar must by notified Director 1¥ Yes 2 □ No Brooklyn Maryland N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 3607 Brooklyn Avenue 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 DYes 2 DNo
If Yes, Give Year or Dates: 197 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after on the Health and Mental Hygiene.
nt: If item 27 is marked other than "natural", or iten Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1968 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced Black 1970 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Bricklayer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beatrice Hall Russell Hall traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3607 Brooklyn Avenue Baltimore, Maryland 21225 Veronica Hall injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/12/09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) **Crownsville Veterans Cemetery** of Funeral Service Licer 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical the as IF FEMALE nse yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 1 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown been signed by should be detact Pagt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð cardiopulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate distress Syndrome 1 ☐ Yes 2 1 No 2 🗆 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 NO 1 Inpatient ပ 2 ☐ ER/Outpatient 3 ☐ DOA this eral Director: After th 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the .. within 24 hours .. To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

5

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records,

Division

State Registrar Reet BAHIMORE MD 2120

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Reynolds

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month - 20<u>09</u> **Physician** Margaret 2. Haas March 4:51 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You Aug. 21, Year) 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖫 F 214-38-8900 Director 90 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Harford Forest Hill 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Sunshine Court Funeral 21050 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Completed by Baltimore, Maryland 21215-0030 Specify:White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 2,2009 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Hoyt မှ Rosie Kostalak Department of Health and M Important: If item 27 Is mar any injury or other traumationce. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Gerrick/Granddaughter 3096 Hadley Dr. York, Pennsylvania 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State March 5. 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Air 22. Name and Address of Facility 2009 Forest Hill, Maryland 21. Signatu of Funera Service Licensee Evans Funeral Chapel & Cremation Service-BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (of as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Industrial Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Haas, Margaret H800421 Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? certificate has treetor, page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this funeral (Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation e Hospital or Attendin 124 hours after death. e Funeral Director: Aft letely filled in by the fur 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) 32. Registrar's Signature

09-01749 Joseph A. Holmes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 06987

		- For State Registrar	Cer	tificate of De	ath		Reg.	No.	
Physicia	n/	Decedent's Name (First, Middle,La	st)		15.		Date of Death	av Year	3. Time of Death
ledical Examin	er	Joseph Haro	n Holmes				March 1, 200)9	1559 hrs
		4a. Facility Name (if not institution, gi			, Town, or Location	on of Death		4c. County of Deat	
		Prince Georges Hospital			everly			Prince George	
Funeral Director			Sex 7. Age (In yrs. la			ours Min.	8. Date of Birth(1		enthplace (State or gn with white North DC)
w any	1	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	o		, , 		10d. Inside City Limits 1 X Yes 2 No
yland F she	힑	10e. Street and Number	r (10f.	-1975		100	Citizen of What Cou	
	I Director	1621 Sham		2	0743			U.S. A	
r death wir	Funeral	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2 X No	If Yes, sp	dent of Hispanic (cify Cuban, Mexic	can, Puerto Ri	can, etc.)	White, etc.	rican Indian, Black,
s afte	출.	Widowed 4 Divorce 15. Decedent's Education (Specify	d If Yes, Give Year or Dates	1 Yes	2 X No spec		rk done	Specify: Office Specify: Offic	
136 thin 72 hours after ne. then "natural", then "natural",	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		vorking life. DO N			ob, King of Business.	
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical	0	17 Father's Name (First, Middle, Las	deard Sc		18.Mot	ther's Name (F	First, Middle, Mar		
O등로드	٤	19a. Informant's Name/Relationship	Type, Print) (Nother)	19b. Mailing Addr	ess (Street and I	Number or Ru	al Route Number	er, City or Town, State	e, Zip Code) 4hts 20743
ore, ME es I and 2 s of Health at If item 27 ther traums	1	20a. Method of Disposition	Removal from State	Place of Disposition (I crematory or other pla	ame of cemetery			Oc. Location - City o	
Baltimore, permit Pages I a Department of He Important: If ite Important or other injury or other in	-	4 Donation 5 Other Special 21. Signature of Funeral Service Lice		day Hill Co	metery nd Address of Fac	03][7/2001	Suitia	814 upshurs
ற் ষైద్≣ हैं Physician	1	a. Pa I. Enter the disease, or con	polications that caused the death	. Do not enter the mo	State le of dying, such a	e - LUX	espiratory arrest	services	Approximate Interval
/Medical	1	failure, List only one cause on							Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence o	f):					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence o						
'60, cate be executed physician and he burial - transit	— L	events resulting in death) Last	Due to (or as a consequence of		01 F/1//	00 mm			
be execician a	Medica	X UNPENDED	AMENDED 23a,2/	perME, g8	91 5/14/	09 TT			
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal de		topic pregnand	су	23d. Date of delive Month	ry Day Year
Bo ne dear	, h	1 Yes 2 No 9 Unknow	9 Olikilowii			D 11	02- Did 4-b		the cause of death?
, P.O. B ires that the d signed by the	٦	Part II. Other significant conditions	contributing to death but not r	esulting in the underly	ing cause given if	n Part I.			obably 4 V Unknown
of Vital Records, Fig. Physician: The law requires the this certificate has been signeral director, page 2 should be	Completed						24a. Was an autopsy perform	prior to	
Vital Rec ysician: The his certificate director, page	8	25. Was case referred to medical examiner?			26.Place of De		nly one)		
Vit hysic this o	P	1 Yes 2 No	Hospital: 1 Inpatient 2 ✓	ER/Outpatient 3	DOA Other			esidence 6 Oth	er:
n of ing Pl After funera		27. Manner of Death 1 X Natural 5 Populing	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at W		l8d. Describe ho	w injury occurred	
ivisior or Attend after death Director;	ξį	2 Accident Pending			1Yes 2				
Division of Vipinal or Attending Phours after death. Icral Director: After titled in by the funeral	Certification:	3 Suicide 6 Could no determine		ome, farm, street, fac	ory, office building	g, etc. 2	or Town, Sta		tural Route Number, City
D To the Hospital within 24 hours. To the Funcral completely filled	Medical		cian: To the best of my knowled er:On the basis of examination a and manner stated.						
F. 3 F. 8	Re	29b. Signature and title of certifier	The mention oracou,		29c. License num	ber	:	29d. Date signed (M	onth, Day,Year)
		DL MU	- MAU		O.C.M.E.			March 3, 2009	
		30. Name and address of person wh Donna M. Vincenti, MD	completed cause of death (Item Assistant Medical Exar		ın Street, Balt	timpre, MD	21201		
Sta Regist		31. Date filed (Month, Day, Year) MAR 0 5 2009	32. Registrar's Signati	barke	 .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day /Medical 4c. County of Death (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Date of Birth (Month, Day, last birthday) 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 216-34-062 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 223a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show important: If Item 27 is marked other than in items in item Director 1 ☐Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with death v Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 __Yes __No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify. ₫ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) Bethleha Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 R 3 Removal from State 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and The law requires that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 🗌 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by g e 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate perform Vital 1 □ Yes 2X No Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natura 5 Pending death. 1 TYes 2 Accident investigation 2 ∏No 24 hours after deatl Funeral Director: filled in by the Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Nurse Practityoner: Medical 29a, Certifier completely within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

а.ш.

27,

FEBRUARY

JOHNSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 28,3009 February Susie Lou Joyce /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) c. County of Death Examiner HAR -RACE Home 2 Year If Unde 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1 □ M 2 🛛 F 236-32-4172 Director 1926 West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 XYes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3800 Hazel Court 21009 by Funeral JSA | 14. Race - American Indian, | White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 □Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeping Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1
Department of Health and Mental Important, if Hem 27 is marked oil any injury or other trammer Garland Thomas Pettry Della Mae Clav 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Hazel Court, Abingdon, Maryland, 21009
of Disposition (Name of Date 20c. Location - City or Town, State Linda S. Insley / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 3/4/2009 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 23a. Part T. Enter the disease, or complications to at caused the death. shock, or heart failure. List only one cause is each line. 2 1317 Cokesbury Road, Abingdon, Maryland 21009 Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** ementis /Medical Due to (or as a connequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) o 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Plage of Death (Check only one) Other: Certification: To 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division or 27. Manuer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print ana Year) State 0 6 2009 Registrar

DHMH 17 Rev 1/2001

JON OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06990 Reg. No. 200 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month -arru AM /Medical 4a. Facility Name of not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Hospital **Baltimore City** n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 DM 2 DF Director 217 66 4605 Apr.29.1951 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shown any Injury or other traumatic event, the Medical Examiner must be notified at once. Director n/a MD Y Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2430 E. Madison St. 2nd floor 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes. Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Roofer F A Taylor and Sons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Jenkins Madeline Diggs ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ratchford / sister 4121 Mountwood Rd. Balto, Md. 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Zion Cem Mar.9,2009 Baltimore, Md. Ignature of Funeral Service Licensee Calvin B. Scruggs Funeral Home Ε. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due, to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at 2 □ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been sig lirector, page 2 should I Completed 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 🗌 Yes 2 No 2 🗌 No 1 TYes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XiYes Other: 4 \square Nursing Home 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending within 24 hours after death. To the Funeral Director: A investigation 2 Accident 1 Tes 2 | No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number . 29d. Date signed (Month, Day, Year)

3

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of

IDRACE

MAR 0 6 2009

31. Date filed (Month, Day, Year)

eath (Item 23a) (Type, Print)

Registrar's Signa

D0035468

MARCH 2, 2000

600 North Wolfe St, Baltimore, MD, 21287

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH Barbara Ann Knutsen 8-56 B 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BATIMORE PITAL BAITIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Days Hours 214-62-9251 Baltimore. July 31. Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Pikesville 1 ☐ Yes 21 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4016 Raleigh Road 21208 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting 18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Guerin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 Raleigh Road Pikesville, MD 21208 20c. Location - City or Town, State Forest Hill, MD Evans Funeral Chapel & Cemation Services 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death DAY 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 2 1No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) MARCH 4th, 2009 HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06992 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Bernard Kuhn. Sr. 3, 2005 March 7:24 P.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 9, 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Days 1X M 2 1 F 215-30-9892 74 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XX Yes 2 ☐ No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6728 Brentwood Avenue 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Stationary Engineer P.Q. Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pancratius Kuhn Hertha Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Kuhn (wife) 6728 Brentwood Avenue Baltimore, Md.21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 3-11-2009Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Raczorowski Funeral Rome, P.A. 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md. Tolad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Small Bowel Obstruction 6 days Due to (or as a consequence of):

Physician /Medical **Examiner**

death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

Items 23a or 28a-f short must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 29a or 2 any injury or other traumatic event, the Modical Examiner must be not prince or the traumatic event.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

the Maryland

physician and s the burial-tran has within 24 hours after death

To the Funeral Director: completely filled in by the fi

Completed by Physician/Medical Examiner

Be

Medical Certification: To

One of the Board o	Supraglottic Laryngeal Car	5 years				
Sequentially list conditions, in any, leading to initiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):					
•	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of Month	delivery Day Year			
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?			
Coronary Arter	y Disease	1 [X Yes 2 □ No 3 □	Probably 4 Unknown			
Chronic Obstru	ctive Pulmonary Disease	performed? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No			
25. Was case referred to medical examiner?		eath (Check only one)				
1 ☐ Yes 2 🙀 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing	Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number o City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 ☑ Certifying P (Check only one)	hysician: To the best of my knowledge, death occurred at the time, date and pla miner: On the basis of examination and/or investigation, in my opinion, death oc	ice, and due to the cause(s) and manne curred at the time, date and place, and	er as stated. due to the cause(s)			

29c. License number

29d. Date signed (Month, Day, Year) March 3, 2009

State

Hospital or

301 St. Paul Place Baltimore, Maryland 21202 31. Date filed (Month, Day, Year) MAR 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Erik Strauss, M.D.

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Amend #18 per FH G889 3/10/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Lawrence William LaFlame, Sr. march 9:04 AM 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Towson Baltimore County If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG • 05 , 1931 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 218-28-6646 77 Director Baltimore, MD. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-1 show othar traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3129 Hiss Ave. 21234 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 is markad othar than "na Elementary/Secondary (0-12) College (1-4or 5+) N/A Lithographer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred E. Inglish George W. LaFlame 19a. Informant's Name/Relationship (Type, Print) $(ext{Wife})$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is rr any injury or othar traurr ance. Mrs.Mary Regina (nee McCubbin) LaFlame 3129 Hiss Ave. Parkville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ich 07, 2009 1 Burial 2 □ Cremation 3 □ Removal from State March Gardens of Faith Cemi ^¹ 4 □ Donation 5 □ Other (Specify) Rossville, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P. A
2325 York Road Timonium, Maryland 21093 of Funeral Service Licensee 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician Cardio pulmonar Day disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown cate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 20 No 2 X No 1 Tes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 XNatural 2 ☐ Accident 5 Pending To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) DOD 59283 mourch Choing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard 7100 North Charles Street Towson LO MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . ^{Day} 2009 **Physician** Dorothy Tobin Mills March 2, 6:00 A /Medical 4a. Facility Name (If not institution, give street and number)
1236 Leeds Terrace Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore 5. Social Security Number 216–14–0591 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, May 20, 9. Birthplace (State or Foreign **Funeral** 1922 1 M 2 XF Months Hours 86 Mary land Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar. Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
The Manager of the marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Modeal Extra traumatic by notified a once. Director Baltimore Baltimore 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1236 Leeds Terrace 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working
We.DO NOT use setting!
Licensed Fractical
Nurse Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Leroy Tobin Charlotte Hayes ပ 19a. Informant's Name/Relationship (Type. Print)
Stephan Mills - Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Albright Court, New Freedom, PA 17349 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) 3-6-2009 Woodlawn, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to () as a consequence of): Examiner ronan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence f): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 □No 1 □Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 21⊠No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier Dukara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Type, Print) 3455 - WLKENS AVE BALTIMORE, MD 21229 31. Date filed (Month, Day, Year) MAR 0 6 2009 Registrar

			For State	State of Marylar		rtment of F tificate of		-	00	09	06995
			Registrar 1. Decedent's Name (First, Middle, Last)			incate of	Death	2. Date of De			3. Time of Death
	Physici /Medic		De	nise Marga	ret Le	eighton	McGowa	n Month	Day 4	2009	12:50 a _M
	Examin	er	4a. Facility Name (If not institution, give s 317 E. North Av			4b. City, Town, or Baltin		th		nty of Dea	th
ay wan	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs		N/A	9. Bir	thplace (State or Foreign
П	Director		214-62-8533	M 2 X F 5.	5 Yrs.	Months Days	Hours Min	9-23-	1953		MD_
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ty, Town or Loc	cation					10d. Inside City Limits
	a-f sh	ctor	MD N/	A Ba	ltimor	e I					1 Yes 2 No
	/ith the	Dire	10e. Street and Number	venue Apt	206	10f. Zip Code			10g. Citizen o	of What Co	
	ns 23a	eral	317 E. North A	Venue Apc 12. Was Decedent Ever in U			.202 ispanic Origin? (Specify Yes or No			erican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Thydical Event and the notified at once.	Completed by Funeral Director	Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1		Vas Decedent of H fYes, specify Cuba □Yes 2⊠No	Specify:	rto Rican, etc.)	Spec	lack, White	
2-0	72 ho "natur	letec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	ient's Usual Occup kind of work done o OO NOT use retired	ation during most of wo	orking	16b. Kind of		•
712	within jiene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) N/A		nician	"		Stell		
Baltimore, Maryland	lid be filed Tental Hyg 'ked other ic event,	To Be C	17. Father's Name (First, Middle, Last) James Louis Leig	,				me (First, Middle, MCGOW	Maiden Surna		
lary	2 should and Nils mail		19a. Informant's Name/Relationship (Тур	oe. Print)	1	g Address (Street			er, City or Tow	ın, State, İ	Zip Code)
e, S	1 and Health em 27 ther tr		Cheryl Edwards- 20a. Method of Disposition			B Edgeme		nue Ba	alto,		21215 Town State
шoг	ages ent of nt: If it ry or o		12 ABurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of natory or other place morial		7-2009		•	town, MD
Balti	permit. I Departm Importal any inju		21. Signature of Funeral Service License		22	Name and Addre	ss of Facility	March E	ast F	/H	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deal						,	Approximate Interval Between
u.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ahrosclerotic Due to (or as a consec		scular D	198652				Onset and Death
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								4 48005
	ecuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chronic Ren		Hickeney					4 years
58760,	certificate be executed adding physician and see as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a consec Astling Ex	caccerba	tion.					25 years
O. Bo	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnanc	у			Date of del	livery Day Year
ds, P.	es the igned be de	β	Part II. Other significant conditions con	tributing to death but not res	ulting in the un	derlying cause give	en in Part I.				o the cause of death?
٥ ۵	aw requir is been s 2 should	Completed						24a. Was	an 24t	o. Were au	utopsy findings available
ž	The	E O						autop perfo 1 ∐Yes	rmed?	death?	completion of cause of
Zita Kita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	ar.	eath (Check only o			
on of	ing Phys	ion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur	y at	Home 5 Residence 1 28d. Describe I			cify)
Division of Vital Records,	To the Hospital or Attending Physician: within L4 hours after death. To the Funeral Director. After this certifies completely filled in by the funeral director, p	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Ru City or Town, State)						ural Route Number,		
	e Hospita 24 hours e Funeral letely filled	Medical C		sician: To the best of my known or the basis of examination and manner stated.							
	To the within To the comp	Me	29b. Signature and title of certifier	7.		29c. Licens	e number		29d. Date sign	ned (Monti	h, Day, Year)
	2		Al Brendonga kyle	MD		D535	17		Murch (05,20	009
	1	-	30. Name and address of person who con	mpleted cause of death (Item	m 23a) (Type, F	Print) Surra 90'1	BALTEMO			-	
	Sta	te	ARNEL MENDOZA TAGLE 31. Date filed (Month Day, Year) ARNO 6 2003	32 Registrar's Signa	ature	A A	F11-151-10	THE PARTY	viny Lil		
	Registr	ar	MAK U 0 200	Lekens ,	8. 46	Made					

State Registrar

OCME 2006

MAR 0 6 2009 /2...

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

war's Signature

29b. Signature and title of certifie

Russell Alexander MD.

31. Date filed (Month, Day, Year)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 24a,25,26,20 and Department of Health and Merital Hygiene 0 0 0 1 - Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** William Mabry February 13, 2009 11:08 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk **Funeral** Months Days Hours unk 1 X M 2 □ F 79 578-34-2424 Director Oct 11, 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
Int. If Item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, Ite Medical Event into 1 and be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4822 Lasalle Road 20782 USA Funeral 12. Was Decedent Ever in U.S.UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 2 Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Carroll Avenue Takoma Park, MD Washington Adventist Hospital 20912 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of I
Important: If It
any Injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) in state 21. Signature of Euneral Service Licenses Ronal S. Wall 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in death) Physician ordnan 100 16 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached it 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 ☐ Yes 2 X No of Vital Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this e Hospital or Attending Phys 24 hours after death. e Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and/manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) 30. Name and address 7600 Carroll Avenue, Takoma Park, MD 20912 32. Registrar's Signature 31. Date filed (Month, Day, State IAR 0 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#10e, f. perFH G889, 376/09 WS
State of Maryland / Department of Health and Mental Hygiene

	•	1 - State Registrar Certificate of Death Reg. No 2009						06998	
Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Month						nth Day Year	3. Time of Death
/Medic		Mary McNoll						eb 27, 2009	0015 ^M
Examin	er	4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
, a company			Center for Hospice C		If Under 1 Year	Tows			ltimore
Funeral Director		5. Social Security Number 245-09-2839 Usual Residence of Decedent	Gex 7. Age (In yrs.	Yrs	Months Days	Hours Min.	8. Date of Birtl (Month, Da) Dec 26	y, Year) (irthplace (State or Foreign Country) No. Carolina
yland 10w		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
the Mar 28a-f sh	Director	Maryland N 10e. Street and Number	I/A		Ba 10f. Zip Code	ltimore		10g. Citizen of What C	1 X Yes 2 No
ath with i	ral Dir	1711 North Bruce				21217 21213		U.S	S.A.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evander or use to resting a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 □ No If Yes, Give X Year or Dates:		Was Decedent of Hi fYes, specify Cubal I□Yes 2☑No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0	ted	15. Decedent's Ed (Specify only highest gra	ducation		lent's Usual Occupa kind of work done d		ina	16b. Kind of Busines	s/Industry
21215-0036 d within 72 hours aft glene. er than "natural", or th M dical Evan.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired,	ook	ing	Private	e Family
Hygied y		17. Father's Name (First, Middle, Last,)				e (First, Middle,	Maiden Surname)	
Maryland td 2 should be file tith and Mental Hy 27 is marked oth r traumatic event	To Be	Charles	Rogers				JoAr	nne Rogers	
ary shou and N s mar	۲	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Numbe	r, City or Town, State,	Zip Code)
y Mand 2		Janette Wilder		40	01 Balfern Av	enue Baltimo	ore, Marylar	nd 21213	
altimore, rmit. Pages 1 ar partment of Hea portant: If Item 2 y Injury or other CE.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispos cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location - City of	r Town, State
tim Fag tment tant: Jury o		4 ☐ Donation 5 ☐ Other (Specif	y) ;		Memorial Pa	111	03/06/09	Windson	Mill, Md.
Ball bermit Depar Impor		21. Standard of Funeral Service Licer	10/50	22	. Name and Addres		ol Capias I	D A	
_ 402.00	\dashv	23a Part . Enter the disease, or com	1. Compressions that dead	J)	1300 Eur	others Funer law Place Ba	timore, Md	21217	Approximate
		shock, or heartfailure. List only Immediate Cause (Final	one cause on each line.		10 000		or respiratory an	rest,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. /SCHEMIC Due to (or as a conseq	CAR	Diomyo	PATHY			YEARS
Examiner			. Due to (or as a conseq	derice or).					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uerice JI).					
ocuted ind	Examiner	triat initiated events	c						
60, be exe		resulting in death) Last	Due to (or as a conseq	uence of):					
68760, ifficate be extended to the street of	Medical		d						
× e ii s	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknowh	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	ildeath 3∟	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
that the hedby	F.	Part II. Other significant conditions of	ontributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds,	od by						1 □ Y	es 2 No 3 I	Probably 4 Unknown
of Vital Records, Physician: The law requires the this certificate has been signe and director, page 2 should be detailed.	Completed						24a. Was a autop: perfor 1 □Yes	sy prior to med? death?	autopsy findings available completion of cause of
itan:	Bec	25. Was case referred to medical examiner?				26. Place of Deat			3 22.110
hysic hysic his ce		1 Yes 2 XNo	Hospital: 1 Inpatient 2 I			4 LJ Nursing Ho	me 5 ☐ Resid	ence 6 Nother (Sp	ecity) HOSFICE
Division of or attending Physafter death. Director: After this din by the funeral din	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work M 1 □ Y	rat ? ∕es 2 □ No	28d. Describe h	ow injury occurred	
Division o To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location <i>(S</i> City or Tow	treet and Number or F n, State)	Rural Route Number,
e Hospit 24 hour e Funera bletely fill.	Medical	29a. Certifier (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the or	cause(s) and manner date and place, and du	as stated. le to the cause(s)
To the withing To the complex	Ž	29b. Signature and title of certifier	3 2		29c. License	number	2	29d. Date signed (Mor	nth, Day, Year)
/		30. Name and address of person who	completed cause of death //-	n 23a\ /Tuna	DC Print)	04395		FEBRUAR	me 21204
5		DANISHE DERSEN	AN MA 6565	N CH	ARLES S	TI SWITE 2	209 6	SALTIMORE	mo 21204
Stat Registra	-	31. Date filed (Month, Day, Year) MAR 0 6 200	330 Registrar's Signal	1. pa	Nes .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Maker Feb 1500 M 2 2009 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Howard County General Hospita Howard olumbia If Unde 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) 1 € M 2 □ F Months Days Hours Min Director 216-50-3683 Feb 8, 1948 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, I'm Medical Evaning must be mainted once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Y☐Yes 2☐No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8706 Airy Brink Lane 21045 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ۵ 1 ☐Yes 2 No Specify. Specify 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Division of Water Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Maker, Sr. Ruby Maker 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cory Maker 1601 Cantwell Road Windsor Mill, Maryland 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 03/09/09 Owings Mills, Md. Garrison Forest Veterans Cemetery of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** spirator /Medical Due to (or as consequence of): Examiner neumania Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the death certificate be executed and A bing attending physician and for use as the buriat-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav ned by the at detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 □Yes 2 1100 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient မ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

9

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1011

10724

Little Paturent Parkway colyapia my 21044

09-01811 Joseph Merenda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of	of Death	2003 0700 Reg. No.
Physi Medical Exa		er JOSEPH FRANCIS MERENDA	2. Date of De Month March 3,	eath 3. Time of Death
		4a. Facility Name (if not institution, give street and number) 1302 Walker Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death None
Funer Directo		5. Social Security Number 220–98–4043 6. Sex 7. Age (In yrs. last birthday) 38 Yr	Months Davis Havis Atm	5/1970 S. Birthplace (State or Foreign Country) MD
vith the Maryland	or or	Usual Residence of Decedent 10a. State 10b. County Maryland None Baltimore		10d. Inside City Limits 1 XXYes 2 No
the Marylia or 28a-f	Direct	1302 Walker Avenue	10f. Zip Code 21239	10g. Citizen of What Country? USA
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland to and Mer-al Hygiene 27 is marked ottler than "natural", or items 23a or 28a-fish	D Vd	1 X X Never Married 2 Married Armed Forces? If Yes 2 X X No If Yes, Give Year or Dates.	as Decedent of Hispanic Origin? (Specify Yes or N Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2XX No specify	white, etc. Specify: White
72 hour	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decede during n	nt's Usual Occupation (Give kind of work done nost of working life, DO NOT use retired)	.16b. Kind of Business/Industry
5-0036 iled within 7 Hygiene I other than	cmp	5+	СРА	Private Practice
1215- Id be filed derrif Hy narked of	Be	∄John Herbert Merenda	18.Mother's Name (First, Middle, Lorene Thelma	Colaw
무 얼 등 등	2	Lorene T Merenda Mother 1302	Walker Avenue Baltimore sition (Name of cemetery, Sate	, Maryland 21239
Baltimore, permit Pages lar Department of Her Important: If ite		1XX Burial 2 Cremation 3 Removal from State Dulaney V	ther place) alley Mausoleum 03/07/0	
		Johnes Xydden UCAARCO	Name and Address of FaMitchell-Wie 6500 York Road Baltim	ore, Maryland 21212
Physicia /Medica xamine	1	23a Fan I. Enter the displace, or combinations that caused the death. Do not enter the failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): amphorage.	ation (heroin, cocaine,	Approximate interval Between Onset and Death
	iner	Sequentially list conditions.		
executed extended in an and	I Examiner			
760, icate be executeder physician and the burial - transit	Medical	X UNPENDED	perME, g889 3/23/09 TT	
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicial filed in by the funeral director, nane 2 should be dearched for use, as the huris	Physician/M		etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
P.O. Best hat the degree by the detached for			underlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ords, P.C. v requires that sbeen signed I should be deta	_		1 Ye	s 2 No 3 Probably 4 Unknown an 24b. Were autopsy findings available
Division of Vital Records, and or Attending Physician: The law requirer staffer cleath. Al Director: After this certificate has been sited in by the funeral director, page 2 should be led in by the funeral director, page 2 should he	l mo		autor	prior to completion of cause of death?
/ital /sician:	o Be	25. Was case referred to medical examiner? Hospital: Inpution 2 ER/Outsetient	26.Place of Death (Check only one) 3 DOA Other Nursing Home 5	Residence 6 ✔ Other: Scene
ion of Vital I tending Physician: eath. After this certifi the funeral director.	tion: To	27 Magnet of Death	njury 28c. Injury at Work? 28d. Describe	how injury occurred
Division To the Hospital or Attent within 24 hours after death To the Functal Director: completely filled in by the	Certification:	2 Accident Investigation Fd 3/3/09 Fd 9:3 Suicide 6 X Could not be determined Homicide Homicide Fd 3/3/09 Fd 9:3 Fd		Street and Number or Rural Route Number, City State) 1302 Walker Ave
To the Hospital within 24 hours: To the Funeral completely filled	Medical		red at the time, date and place, and due to the caus	e(s) and manner as stated.
D	Σ	29b. Signature and title of certifier	29c, License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 4, 2009
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Peni	n Street, Baltimore, MD 21201	
Regis				
DHMH 17 Rev 1/ OCME 2006	2001	MAR V 2005 Jenewa J. Riginal		OCME